IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

CERTIFIED MAIL: 7007 0710 0002 7979 0734

March 30, 2010

James Adamson
Mountain View Hospital
2325 Coronado Street
Idaho Falls, ID 83404

RE: Mountain View Hospital, provider #130065

Dear Mr. Adamson:

Based on the survey completed at Mountain View Hospital, on March 15, 2010, by our staff, we have determined Mountain View Hospital, is out of compliance with the Medicare Hospital **Conditions of Participation on Governing Body (42 CFR 482.12), Patient Rights (42 CFR 482.13), Pharmaceutical Services (42 CFR 482.25) and Infection Control (42 CFR 482.42)**. To participate as a provider of services in the Medicare Program, a hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused these conditions to be unmet, substantially limit the capacity of Mountain View Hospital, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed, also, is a similar form describing State licensure deficiencies.

You have an opportunity to make corrections of those deficiencies which led to the finding of non-compliance with the Conditions of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the POC is effective in bringing the hospital into compliance, and that the hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of each form.

Such corrections must be achieved and compliance verified by this office, before April 29, 2010. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than April 20, 2010.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **April 12, 2010**.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626.

Sincerely,

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/mlw

ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Kate Mitchell, CMS Region X Office

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130065	A. BUILDING _____ B. WING _____	03/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HOSPITAL	2325 CORONADO STREET IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your hospital. Surveyors conducting the survey were: Patrick Hendrickson, RN, HFS, Team Leader Aimee Hastriter, RN, HFS Acronyms used in this report include: CCN - Critical Care Nursery CNA- Certified Nurse Assistant CoP - Conditions of Participation CPR - Cardiopulmonary Resuscitation Code Green - Violent Patient and/or Visitor CRNA - Certified Registered Nurse Anesthetist FDA - Food and Drug Administration H&P - History and Physical IM - Intramuscular IV - Intravenous IVP- Intravenous Push M.A.R. - Medication Administration Record ML - Milliliters MG - Milligrams PACU - Post Anesthesia Care Unit PRN - As Needed RN - Registered Nurse	A 000		
A 043	482.12 GOVERNING BODY The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. This CONDITION is not met as evidenced by: Based on medical record review, review of	A 043	PLAN OF CORRECTION AND POLICY CHANGES ARE REVIEWED AND APPROVED BY BOARD OF MANAGERS CEO 4-15-10	Completion date: 4/19/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

...y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 115	Continued From page 2 medical records, hospital policies, and employee training records, it was determined the hospital failed to protect and promote patients' rights. This resulted in the inability of the hospital to respond in systematic ways to ensure safe and effective care was provided. Findings include: 1. Refer to A131 for the hospital's failure to ensure patients, or their representatives, were allowed to make informed decisions regarding their care. 2. Refer to A144 for the hospital's failure to provide a safe environment for patient care. 3. Refer to A164 for the hospital's failure to ensure that patients who were restrained both physically and chemically, had a comprehensive assessment which included information to determine less restrictive interventions were ineffective. 4. Refer to A166 for the hospital's failure to ensure hospital staff incorporated restraint usage into each patient's plan of care. 5. Refer to A167 for the hospital's failure to ensure safe and appropriate restraint techniques were defined by hospital policy. 6. Refer to A168 for the hospital's failure to ensure patients, who were physically restrained, had a complete physician's order for the physical restraints. 7. Refer to A169 for the hospital's failure to ensure restraint orders were not written as PRN orders.	A 115		

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A 115	Continued From page 3 8. Refer to A178 for the hospital's failure to ensure patients, who had restraints applied for the management of violent behavior, received a face-to-face evaluation by an appropriately qualified person within 1-hour of initiation of the intervention. 9. Refer to A196 for the hospital's failure to ensure direct care staff demonstrated competency with restraint application. 10. Refer to A207 for the hospital's failure to ensure that staff that provided restraint training were qualified to teach the course. The cumulative effect of these deficient systemic practices compromised the hospital's ability to keep patients safe, and prevented staff from utilizing restraints in a consistent manner.	A 115		
A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This STANDARD is not met as evidenced by: Based on interview and review of medical records and policies, it was determined the hospital failed to ensure patients were allowed to make informed decisions regarding their care for 12 of 12	A 131	PLAN OF CORRECTION	

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A 131	Continued From page 4 patients, (#1 - #6, #15 - #18, #27 and #37) whose medical records were reviewed for proper surgical consents. This resulted in a lack of informed consents prior to surgery. Findings include: 1. The hospital's "INFORMED CONSENT" policy, revised January of 2010, stated the informed consent process included identification of the physician or other practitioners who had primary responsibility for the patient's care, as well as, the identity and professional status of the individual responsible for authorizing and performing a procedure or treatment. However, the hospital failed to obtain fully informed consents as follows: a. Patient #1 was a 51-year-old female who had an endoscopic assisted left carpal tunnel release on 3/08/10. The Consent for Anesthesia Services, that was not dated or timed, stated, "I hereby consent to the anesthesia services and authorize that it be administered by [name of anesthesia group] or their associates..." The consent did not specify who was going to provide the anesthesia or their title. The deficient consent was confirmed on 3/09/10 at 2:45 PM, with the hospital's Compliance Officer and the Director of Surgical Services. b. Patient #2 was a 55-year-old female who had a laparoscopic cholecystectomy on 3/08/10. The Consent for Anesthesia Services, that was dated 3/08/10 at 11:00 AM, stated, "I hereby consent to the anesthesia services and authorize that it be administered by [name of anesthesia group] or their associates..." The consent did not specify who was going to provide the anesthesia or their title. Further, Patient #2's operative report stated that a second physician assisted with the surgery.	A 131	A131 PLAN: 1. Educate Anesthesia providers of: A. "INFORMED CONSENT" policy B. Each provider name is on the consent for Anesthesia C. Need for specific Anesthesia Type on consent 2. Staff Education on the need for all providers to be identified on the Informed Consent this will need to include any and all assistants. RESPONSE: 1. Letter to inform Anesthesia of need for identification 2. Change form to include spaee for Anesthesia provider to be identified 3. Audit Pre-Op Informed Consents for all providers listed and assistants are listed on the Informed Consent. If provider/assistant is not list than the proeedure will not be allowed to enter the Operating Room Suite until consent is properly filled out. An Oeeurrenee report will be generated if eonsent is not eompleted prior to procedure. 4. PACU audit for Anesthesia providers to identify providers that are not compliant with the following areas: A. Type of Anesthesia given B. Provider is identified on IC form C. Document is signed timed and dated	

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A 131	Continued From page 5 The surgical consent stated the procedure would be performed by Patient #2's attending physician and "whoever he may designate as assistants." The consent did not specify who was going to be his assistant or their title. The deficient consents were confirmed on 3/09/10 at 2:35 PM, with the hospital's Compliance Officer and the Director of Surgical Services. c. Patient #3 was a 1-year-old female who had a dental procedure on 3/08/10. The Consent for Anesthesia Services, dated 3/08/10 un-timed, stated, "I hereby consent to the anesthesia services and authorize that it be administered by [name of anesthesia group] or their associates..." The consent did not specify who was going to provide the anesthesia or their title. The deficient consent was confirmed on 3/09/10 at 2:40 PM, with the hospital's Compliance Officer and the Director of Surgical Services. d. Patient #4 was a 77-year-old male who had a repair on his left middle finger on 3/08/10. The Consent for Anesthesia Services, dated 3/08/10 at 8:50 AM, stated, "I hereby consent to the anesthesia services and authorize that it be administered by [name of anesthesia group] or their associates..." The consent did not specify who was going to provide the anesthesia or their title. Additionally, the consent did not list the type of anesthesia to be used. The deficient consent was confirmed on 3/09/10 at 2:55 PM, with the hospital's Compliance Officer and the Director of Surgical Services. e. Patient #5 was a 74-year-old male who had a right shoulder arthroscopy on 3/08/10. The Consent for Anesthesia Services, dated 3/08/10 and un-timed, stated, "I hereby consent to the	A 131	A131 EVIDENCE: TAB 1 SEC 1: Copy of changed "INFORMED CONSENT" for Anesthesia services SEC 2: Copy of "informed consent audit tool" SEC 3: Copy of Letter sent to all Anesthesia providers SEC 4:	

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A 131	Continued From page 6 anesthesia services and authorize that it be administered by [name of anesthesia group] or their associates..." The consent did not specify who was going to provide the anesthesia or their title. The deficient consent was confirmed on 3/09/10 at 2:52 PM, with the hospital's Compliance Officer and the Director of Surgical Services. f. Patient #6 was a 63-year-old male who had a right knee arthroscopy on 3/08/10. The Consent for Anesthesia Services, dated 3/08/10 timed 8:10 PM, stated, "I hereby consent to the anesthesia services and authorize that it be administered by [name of anesthesia group] or their associates..." The consent did not specify who was going to provide the anesthesia or their title. Additionally, the consent did not list the type of anesthesia to be used. The deficient consent was confirmed on 3/09/10 at 2:58 PM, with the hospital's Compliance Officer and the Director of Surgical Services. g. Patient #15 was a 74-year-old female who had a left total knee replacement on 3/09/10. The Consent for Anesthesia Services, dated 3/09/10 timed 5:38 AM, stated, "I hereby consent to the anesthesia services and authorize that it be administered by [name of anesthesia group] or their associates..." The consent did not specify who was going to provide the anesthesia or their title. The deficient consent was confirmed on 3/09/10 at 2:56 PM, with the hospital's Compliance Officer and the Director of Surgical Services. h. Patient #16 was a 69-year-old male who had a right total knee replacement on 3/09/10. The Consent for Anesthesia Services, dated 3/09/10	A 131		

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A 131	Continued From page 7 and un-timed, stated, "I hereby consent to the anesthesia services and authorize that it be administered by [name of anesthesia group] or their associates..." The consent did not specify who was going to provide the anesthesia or their title. The deficient consent was confirmed on 3/09/10 at 2:38 PM, with the hospital's Compliance Officer and the Director of Surgical Services. i. Patient #17 was a 79-year-old male who had a left shoulder arthroscopy on 3/09/10. The Consent for Anesthesia Services, dated 3/09/10 timed 5:30 AM, stated, "I hereby consent to the anesthesia services and authorize that it be administered by [name of anesthesia group] or their associates..." The consent did not specify who was going to provide the anesthesia or their title. Additionally, the consent did not list the type of anesthesia to be used. The deficient consent was confirmed on 3/09/10 at 2:26 PM, with the hospital's Compliance Officer and the Director of Surgical Services. j. Patient #18 was a 67-year-old female who had a cystoscopy with placement of lighted stents on 3/09/10. The Consent for Anesthesia Services, dated 3/09/10 at 5:40 AM, stated, "I hereby consent to the anesthesia services and authorize that it be administered by [name of anesthesia group] or their associates..." The consent did not specify who was going to provide the anesthesia or their title. Additionally, the consent did not list the type of anesthesia to be used. Further, Patient #18's Operative Record, dated 3/09/10 stated a second physician assisted with the surgery. The surgical consent stated the procedure would be performed by Patient #18's attending physician and "whoever he may	A 131		

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A 131	Continued From page 8 designate as assistants." The consent did not specify who was going to be his assistant or their title. The deficient consents were confirmed on 3/09/10 at 2:16 PM, with the hospital's Compliance Officer and the Director of Surgical Services. k. Patient #27 was a 70-year-old male who had a left total knee arthroplasty on 5/15/09. The Consent for Anesthesia Services, that was not dated or timed stated, "I hereby consent to the anesthesia services and authorize that it be administered by [name of anesthesia group] or their associates..." The consent did not specify who was going to provide the anesthesia or their title. Additionally, the consent did not list the type of anesthesia to be used. The deficient consent was confirmed on 3/10/10 at 10:05 AM, with the hospital's Compliance Officer. l. Patient #37 was a 76-year-old female who had a plastic surgery procedure on 3/08/10. The Consent for Anesthesia Services, dated 3/08/10 at 5:45 AM, stated, "I hereby consent to the anesthesia services and authorize that it be administered by [name of anesthesia group] or their associates..." The consent did not specify who was going to provide the anesthesia or their title. Additionally, the consent did not list the type of anesthesia to be used. The deficient consent was confirmed on 3/09/10 at 3:05 PM, with the hospital's Compliance Officer and the Director of Surgical Services. When asked, on 3/09/10 at 3:55 PM, the hospital's Compliance Officer stated that patients could not give consent to a group of professionals, but rather an individual.	A 131	Completion date: 4/19/2010	

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A 131	Continued From page 9 The facility failed to ensure patients were given comprehensive information necessary to make a fully informed decision regarding surgical care.	A 131		
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on observations, medical record review, review of hospital policies and staff interview, it was determined the hospital failed to ensure a safe environment for patient care. This directly impacted 8 of 38 patients, (#18, #21, #27, #28 - #31 and #38) whose records were reviewed and/or whose care was observed, and had the potential to impact all patients treated at the facility. This failure had the potential to expose patients to infections and/or suffer injures. Findings include: 1. The hospital's Surgical Department was toured on 3/08/10 from 1:43 PM to 3:45 PM. During the tour it was noted Warmer #4 contained a 1 liter bottle of sterile water and a 1 liter bottle of sodium chloride. These bottles were available for patient use. The noted temperature of the warmer was 155 degrees. Warmer #3 had a 1 liter bottle of sterile water. This bottle was available for patient use. The noted temperature of the warmer was 156 degrees. Warmer #2 had several 3 liter bags of irrigation fluids. These bags were available for patient use. The noted temperature of the warmer was 156 degrees. The Consumer Product Safety Commission states an approximate one-second exposure to 160° degrees water would result in third degree	A 144	A144 PLAN: 1) Warmers through out MVH have been labeled with the appropriate signs to indicate what warmer should have blankets and which warmer should have patient fluids. The content will be inspeeted every time the warmer temperature is checked. RESPONSE: 1) Staff education by "MANDATORY READ E-MAIL" to all clinical staff members. Managers review with departments that were sited. 2)Posting of signs on both blanket warmers and fluid warmers to remind staff of what products go where. 3)Temperatures ranges posted on all warmers. 4) Safety rounds will be performed monthly. Warmers both blanket and fluid will be checked for content. EVIDENCE: 1) TAB 2 SEC 1: picture of warmer with sign SEC 2: sample Monthly Safety rounds check list with warmer check.	

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A 144	Continued From page 10 burns. When the water was 130° degrees, an approximate half-minute exposure would result in third degree burns. The Director of Surgical Services was interviewed on 3/08/10 between 1:43 PM to 3:45 PM. She stated that to her understanding, the above fluids were used to clean equipment and soften endotracheal tubes. She stated that it could be possible, in a rush, a staff member might grab the hot fluid and use it on a patient. The Director of Surgical Services removed the fluids from the warmers at the time of the observation. The hospital failed to ensure patients were not placed at risk of receiving burns. 2. Patient #27 was a 70-year-old male who had a left total knee arthroplasty on 5/15/09. A Physician's verbal order from Patient #27's Internal-Medicine physician, dated 5/18/09 at 6:30 AM, stated that staff were to give Narcan 0.4 mg IV first, then Haldol 2 mg IV second, and then Ativan 1 mg IV. The order continued to direct nursing staff to give Ativan 1 mg as needed as often as needed until the physician's arrival. Ativan 1 mg was given according to Patient #27's 5/18/09 M.A.R. at 6:50 AM. The nurse noted that a physician was in to see Patient #27 at 6:55 AM on 5/18/10. Patient #27's record did not contain any further Ativan orders and nursing staff gave excessive Ativan without physician orders as followed; a. A nursing note dated 5/18/09 at 8:00 AM, stated Patient #27 was trying to get out of bed and at 8:20 AM the patient was given Ativan 1 mg IVP. This was confirmed by Patient #27's 5/18/09 M.A.R.	A 144	Warmers Completion date: 4/19/2010 A144, A164, A166, A167, A168, A178 A 196, A207 Continue PLAN FOR CORRECTION: RESTRAINT & MEDICATION REVIEW PLAN: 1) Designate a Supervising RN to be the facility restraint coordinator. 2) Receive formal training for "Restrain Coordinator" 3)Revise Hospital restraint policy to include all A. physically and chemically are defined B. restraint techniques are defined C. complete physician order and documen-tation is defined D. What an appropriate order and inappropriate order is define	

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A 144	Continued From page 11	A 144	PLAN CONTINUES:	

b. The 5/18/09 nursing note further documented that at 10:20 AM, Patient #27 was verbally abusive and continued to get out of bed. The note stated that Ativan 1 mg IVP was given. This was confirmed by Patient #27's 5/18/09 M.A.R. The 5/18/09 M.A.R. also documented the nurse gave Patient #27 Ativan 1 mg at 10:30 AM, 10:40 AM, and 11:00 AM.

c. Patient #27's 5/18/09 nursing notes further documented that at 4:15 PM, Patient #27 was verbally abusive and continued to get out of bed. The note stated Ativan 1 mg IVP was given. This was confirmed by Patient #27's 5/18/09 M.A.R.

d. The 5/18/09 nursing notes further documented that at 4:30 PM, Patient #27 was restrained by 3 staff members. The note documented that the staff used a "sheet" to prevent Patient #27 from "self harm." The note stated that Ativan 1 mg IVP was given. This was confirmed by Patient #27's 5/18/09 M.A.R.

e. Patient #27's M.A.R. documented that on 5/18/09 at 7:55 PM, Patient #27 was given Ativan 1 mg IVP. There was no documented nursing note as to why the Ativan was given.

f. A nursing note dated 5/18/09 at 10:00 PM, stated Patient #27 was restless, agitated and trying to get out of bed by crawling over the rails. The note stated that Ativan 1 mg was given. This was also documented on Patient #27's 5/18/09 M.A.R.

g. A nursing note dated 5/18/09 at 11:00 PM, stated Patient #27 was agitated and that Ativan 1 mg was given. This was also documented on

E.all restraint orders are followed by a face to face by ordering physician with 1 hour of initiation.

F. Training requirements are define both upon hire and annually.

G. Training is done by someone that has received appropriate formal training.

H. All RN/LPN will demonstrate the safe application and use of all types of restraints used by staff.

I. All chemical restraints will have a pharmacist review and documented on restraint flow sheet.

J. Pharmacist will review for proper medication administration.

EVIDENCE:

1)Training:

A. TAB 3 SEC 1 overview plan

B. TAB 3 SEC 2: health Stream Course staff orientation to revised policy health stream course question

C. SEC 3: formal training for restraint cord course outline and attendance.

D. SEC 4: revised policy on restraints

E. SEC 5: sample "Restraint flow sheet"

F. SEC 6: sample of "Restraint Log"

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A 144	Continued From page 12 Patient #27's 5/18/09 M.A.R. h. A physician's verbal order dated 5/18/09 at 11:30 PM, ordered Ativan 2 mg IV x 1. Patient #27's M.A.R. did not document that the nurse had given the Ativan. However, Patient #27's M.A.R. documented that on 5/18/09 at 11:45 PM, Patient #27 was given Ativan 1 mg IVP again. There was no documented nursing note as to why the 11:45 PM Ativan was given. i. Patient #27's M.A.R. documented he received Ativan 1 mg IV on 5/19/09 at 12:30 AM. There was no documented nursing note as to why the Ativan was given. j. A Nursing note dated 5/19/09 at 2:00 AM, stated that Patient #27 was restless and IV Ativan was given. No dose was documented. The Ativan dose was not documented on Patient #27's M.A.R. k. A Nursing note dated 5/19/09 at 5:00 AM, stated that Patient #27 was thrashing and required two staff members to hold him down. The note documented that Ativan was given. This was not documented on Patient #27's M.A.R. nor was any dosage amount found. l. A Nursing note dated 5/19/09 at 6:00 AM, stated that Patient #27 was agitated. The note documented that Ativan was given. This was documented on Patient #27's 5/19/09 M.A.R. as 1 mg IVP. On 5/19/09 at 6:38 AM, the patient was found unresponsive and pulseless. CPR was initiated and Patient #27 was transferred to another hospital where he did not recover from the	A 144	EVIDENCE continues: G. SEC 7: sample "Code Green Policy" ALL TRAINING WITH BOTH ON-LINE AND CMS APPROVED DVD FOR RN/LPN WILL BE COMPLETED AND DOCUMENTED BY 4/19/2010 DIDACITAL WILL BE COMPLETED ON 4/27/2010 BECAUSE OF RESTRAINT COORDIN ATOR FORMAL TRAINING COURSE IS NOT COMPLETED UNTIL 4/22/2010 ALL OTHER CODE GREEN TEAM RESTRAINT TRAINING WILL BE DONE ON LINE USING THE HEALTH STREAM COURSE THAT REQUIRES RESTRAINT POLICY ORIENTATION COMPLETED AND DOCUMENTED BY 4/19/2010	

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A 144	Continued From page 13 cardiac arrest and passed away on 5/24/09. Patient #27's record documented the patient had received 16 confirmed mg of Ativan in a 23 hour and 30 minute period. Further, The record contained an additional 2 mg of Ativan that was not confirmed as given. The hospital's "PATIENT RESTRAINT POLICY," revised 6/05 stated that when chemical restraints were prescribed the order should include the maximum dose to be given in 24 hour period. The Nursing 2010 Drug Handbook stated that Ativan (a medication used for anxiety) should not exceed dosing of 10 mg a day. This recommendation was not followed. On 3/11/09 at 2:18 PM, the hospital's Compliance Officer was interviewed. He stated that during a review of the case, it was identified that Ativan was used excessively. 3. Refer to A164 for the hospital's failure to ensure that patients who were restrained both physically and chemically, had a comprehensive assessment which included information to determine that less restrictive interventions were ineffective. 4. Refer to A166 for the hospital's failure to ensure hospital staff incorporated restraint usage into each patient's plan of care. 5. Refer to A167 for the hospital's failure to ensure safe and appropriate restraint techniques were defined by hospital policy. 6. Refer to A168 for the hospital's failure to ensure patients, who were physically restrained, had complete physician's order for the physical restraints.	A 144	REFER TO "RESTRAINT POLICY" TAB 3 SEC 4 & "RESTRAINT FLOW SHEET" TAB 3 SEC 5. A166 REFER TO TAB 3 SEC 4 "RESTRAINT POLICY" page 7 8.3 A167 REFER TO TAB 3 SEC 4 page 1 1 - 1.6 A168 REFER TO TAB 3 SEC 4 page 6 PATIENT CARE MANAGEMENT 1 - 9	

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A 144	Continued From page 14 7. Refer to A169 for the hospital's failure to ensure restraint orders were not written as PRN orders. 8. Refer to A178 for the hospital's failure to ensure patients, who had restraints applied for the management of violent behavior, received a face-to-face evaluation by an appropriately qualified person within 1-hour initiation of the intervention. 9. Refer to A196 for the hospital's failure to ensure direct care staff demonstrated competency with restraint application. 10. Refer to A207 for the hospital's failure to ensure staff who provided restraint training were qualified to teach the course. 11. Refer to A491 as it relates to the facility's failure to ensure out-patient clinics, who distributed patient samples, had properly documented obtaining and dispensing sample medications in accordance with accepted professional standards and that off-label use of a medication had been properly approved. This failure directly impacted Patients #28 - #31. 12. Refer to A500 as it relates to the facility's failure to ensure patient safety with a pharmacist review of medication orders prior to administration to patients. This failure directly impacted Patients #18 and #21. 13. Refer to A502 as it relates to the facility's failure to ensure all drugs were stored in a secure location in the Surgical Department, Labor & Delivery Department, and in the Out-Patient	A 144	A169 REFER TO TAB 3 SEC 4 page 6 number 5 A178 REFER TO TAB 3 SEC 4 page 6 number 1 A196 REFER TO TAB 3 SEC 4 page 9 "TRAINING FOR MEDICAL AND CHEMICAL RESTRAINTS" A207 REFER TO TAB 3 SEC 3 formal training course for restraint coordinator. A491 REFER TO TAB 4 SEC 1 P & T meeting minutes on April 7, 2010 approved the off label use of I.V. Haldol for chemical restraint and anesthesia use only. A500 REFER TO TAB 5 A502 REFER TO TAB 5	

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A 144	Continued From page 15 Clinic. 14. Refer to A503 as it relates to the facility's failure to ensure Schedule II, III, IV, and V drugs (controlled substances) were locked within a secure area in the Surgical Department and the Labor & Delivery Department. 15. Refer to A505 as it relates to the facility's failure to ensure outdated medication was not available for use. 16. Refer to A536 as it relates to the facility's failure to ensure proper safety precautions were utilized for Patient #38. 17. Refer to A747 for the hospital's failure to provide a sanitary environment and promote safe practices to avoid sources and transmission of potential infection. The cumulative effect of these deficient facility practices impeded to ability of the facility to promote and protect the safety of patients.	A 144	A503 REFER TO TAB 5 REFER TO TAB 5 REFER TO TAB 6 REFER TO TAB 7	
A 164	482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. This STANDARD is not met as evidenced by: Based on interview and review of clinical records and policies, it was determined the hospital failed to ensure 1 of 1 patient (#27) reviewed, who was both physically and chemically restrained, had a comprehensive assessment related to the restrain use. This resulted in the patient not	A 164	A164 REFER TO A141 FOR PLAN, RESPONSE AND EVIDENCE. REFER TO TAB 3	

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A 164	Continued From page 16 being assessed comprehensively assess for the use of restrains. Findings include: 1. Patient #27 was a 70-year-old male who had a left total knee arthroplasty on 5/15/09. His M.A.R. and nursing notes documented he was physically and chemically restrained with out comprehensive assessment related to the use of the restraints as follows: A nursing note dated 5/18/09 at 6:22 AM, stated Patient #27 stated he could not breathe and took off his bi-pap. The patient was described as cussing at the staff, uncooperative, yanking tubing, trying to crawl out of bed over the side rails, and trying to hit staff. The note documented that a Code Green was called and at 6:25 AM, the patient was restrained on the floor by 8 staff members. The note stated that at 6:27 AM, the physician was told of the incident and chemical restraint orders (Ativan and Haldol) were obtained. A Physician's verbal order from Patient #27's Internal Medicine physician, dated 5/18/09 at 6:30 AM, stated that staff were to give Narcan 0.4 mg IV first, then Haldol 2 mg IV second, and then Ativan 1 mg IV. The order continued to direct nursing staff to give Ativan 1 mg, as needed, as often as needed until the physician's arrival. Ativan 1 mg was given according to Patient #27's 5/18/09 M.A.R. at 6:50 AM. The nurse noted that a physician was in to see Patient # 27 at 6:55 AM. However, Patient #27's M.A.R. and nursing notes documented he continued to be physically and chemically restrained as follows: - 5/18/09 at 8:03 AM: a nursing note stated	A 164		

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A 164	Continued From page 17 Patient #27 continued to try to get out of bed and was assisted to the floor. - 5/18/09 at 8:20 AM: he was given Ativan 1 mg IVP. A physician's verbal order, dated 5/18/09 at 8:40 AM, ordered Haldol IV/IM every 6 hours as needed for agitation. - 5/18/09 at 8:55 AM: he was given Haldol 5 mg IV. - 5/18/09 at 10:20 AM: he was given Ativan 1 mg IVP. - 5/18/09 at 10:30 AM: he was given Ativan 1 mg IVP. - 5/18/09 at 10:40 AM: he was given Ativan 1 mg IVP. - 5/18/09 at 11:00 AM: he was given Ativan 1 mg IVP. - 5/18/09 at 4:15 PM: he was given Ativan 1 mg IVP. - 5/18/09 at 4:30 PM: he was given Ativan 1 mg IVP. His nursing note also documented Patient #27 was restrained by 3 staff members and staff used a "sheet" to prevent him from "self harm." A physician's verbal order dated 5/18/09 at 5:00 PM, instructed the Haldol to be increased to 10 mg IV/IM every 4 hours, as needed, for agitation. - 5/18/09 at 6:55 PM: he was given Haldol 10 mg IM. - 5/18/09 at 7:55 PM: he was given Ativan 1 mg IVP. - 5/18/09 at 10:00 PM: he was given Ativan 1 mg IVP. - 5/18/09 at 11:00 PM: he was given Ativan 1 mg IVP and Haldol 10 mg IVP.	A 164	REFER TO TAB 3 REFER TO TAB 5	

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A 164	Continued From page 18 A physician's verbal order dated 5/18/09 at 11:30 PM, ordered Ativan 2 mg IV x 1. Patient #27's M.A.R. did not document that the nurse had followed the order. However, his MAR and nursing notes documented he received the following: - 5/18/09 at 11:45 PM: he was given Ativan 1 mg IVP. - 5/19/09 at 12:30 AM: he was given Ativan 1 mg IVP. - 5/19/09 at 2:00 AM: he was given Ativan IVP. The dose was not documented. - 5/19/09 at 3:00 AM: he was given Haldol 10 mg IM. - 5/19/09 at 5:00 AM: he was given Ativan. The dose he received was not documented. Additionally, his nursing note stated he was thrashing and needed two staff members to hold him down. - 5/19/09 at 6:00 AM: he was given Ativan 1 mg IVP. On 5/19/09 at 6:38 AM, Patient #27 was found unresponsive and pulseless. CPR was initiated and he was transferred to another hospital where he did not recover from the cardiac arrest and passed away on 5/24/09. Patient #27's record did not include comprehensive restraint assessment information (i.e. the risks associated with the use of the restraint, the introduction of less restrictive measures and alternatives attempted and the rationale for not using alternatives, an assessment of Patient #27's condition, needs, strengths, weaknesses, and preferences, and environmental factors) for any of the above listed restraints. Addltional, the facility failed to	A 164		

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A 164	Continued From page 19 consistently document an immediate and/or serious danger to the physical safety of the patient or others, which made the restraint use necessary. The hospital's "Patient Restraint Policy," revised on 6/05, was reviewed. The policy did not direct staff to assess and document the risks associated with the use of the restraint, introduction of less restrictive measures and alternatives attempted and the rationale for not using alternatives, an assessment of the patient's condition, needs, strengths, weaknesses, preferences, and environmental factors or the immediate and/or serious danger to the physical safety of the patient or others. The hospital's Compliance Officer was interviewed on 3/11/10 starting at 2:18 PM. He confirmed the policy was not descriptive and did not describe what a comprehensive restraint assessment should include. He further stated staff and physicians had failed to document a comprehensive restraint assessment for Patient #27. The hospital failed to ensure Patient #27, who was restrained both physically and chemically, had a complete comprehensive restraint assessment.	A 164	REFER TO TAB 3	A164 Completion date: 4/19/2010
A 166	482.13(e)(4)(i) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be-- (i) in accordance with a written modification to the patient's plan of care. This STANDARD is not met as evidenced by: Based on staff interview and review of medical	A 166	REFER TO TAB 3	

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A 166	Continued From page 20 records and hospital policies, it was determined the hospital failed to ensure hospital staff incorporated restraint usage into a patient's plan of care for 1 of 1 patient (#27) reviewed, who was physically and chemically restrained. This resulted in lack of knowledge with the process of restraint assessments, interventions and evaluations of restraint usage and had the potential to interfere with coordination of patient care. Findings include: 1. Patient #27 was a 70-year-old male who had a left total knee arthroplasty on 5/15/09. His record documented he was physically and chemically restrained as follows: - A nursing note dated 5/18/09 stated at 6:25 AM, the patient was physically restrained on the floor with 8 staff members. The note further stated that at 6:27 AM, the physician was told of the incident and medication restraint orders were obtained. A Physician's verbal order from Patient #27's Internal-Medicine physician dated 5/18/09 at 6:30 AM, stated that staff were to give Narcan 0.4 mg IV first, then Haldol (a medication used for psychosis considered a chemical restraint) 2 mg IV second, and then Ativan (a medication used for anxiety and could be considered a chemical restraint) 1 mg IV. The order continued to direct nursing staff to give Ativan 1 mg as needed, as often as needed until the physician's arrival. - Ativan 1 mg was given according to Patient #27's 5/18/09's M.A.R. at 6:50 AM. - On 5/18/09 6:43 AM, a nurse noted that 6 staff members were still physically restraining Patient #27 while they administered the medications. The nursing note stated Patient #27 continued to	A 166	REFER TO TAB 3	

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A 166	Continued From page 21 try to get out of bed and at 8:03 AM, a second Code Green was called and Patient #27 was assisted to the floor and physically restrained. - Patient #27's M.A.R. and nursing note dated 5/18/09 at 8:00 AM, stated Patient #27 was trying to get out of bed and at 8:20 AM, the patient was given Ativan 1 mg IVP. A physician's verbal order dated 5/18/09 at 8:40 AM, ordered Haldol 5 mg IV/IM every 6 hours as needed for agitation. - Patient #27's M.A.R. and nursing notes documented that Haldol 5 mg IV was given on 5/18/09 at 8:55 AM. - The 5/18/09 nursing notes further documented that at 10:20 AM, Patient #27 was verbally abusive and continued to get out of bed. The note stated that Ativan 1 mg IVP was given. This was confirmed by Patient #27's 5/18/09 M.A.R. - Patient #27's 5/18/09 M.A.R. documented he received Ativan 1 mg at 10:30 AM, 10:40 AM, and 11:00 AM. - Patient #27's nursing notes documented that at 4:30 PM, he was restrained by 3 staff members. The note documented that the staff used a "sheet" to prevent Patient #27 from "self harm." The note stated that Ativan 1 mg IVP was given. This was confirmed by Patient #27's 5/18/09 M.A.R. A physician's verbal order dated 5/18/09 at 5:00 PM, ordered the Haldol to be increased to 10 mg IV/IM every 4 hours as needed for agitation.	A 166		

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	130065	A. BUILDING _____ B. WING _____	03/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HOSPITAL	2325 CORONADO STREET IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 166	Continued From page 22 - Patient #27's 5/18/09 M.A.R. and nursing notes documented that at 6:55 PM, Patient #27 was verbally abusive and continued to try to get out of bed. The note stated that Haldol 10 mg was given IM. - Patient #27's M.A.R. documented that on 5/18/09 at 7:55 PM, he was given Ativan 1 mg IVP. There was no documented nursing note as to why the Ativan was given. - Patient #27's 5/18/09 M.A.R. and nursing notes dated 5/18/09 at 10:00 PM, stated Patient #27 was given Ativan 1 mg due to being restless, agitated and trying to get out of bed by crawling over the rails. - Patient #27's 5/18/09 M.A.R. documented that Haldol 10 mg IVP and Ativan 1 mg was given at 11:00 PM. A corresponding nursing note stated Patient #27 was agitated and that Ativan 1 mg was given. - Patient #27's M.A.R. documented that on 5/18/09 at 11:45 PM, Patient #27 was given Ativan 1 mg IVP. There was no documented nursing note as to why the Ativan was given. - Patient #27's M.A.R. documented he received Ativan 1 mg IV on 5/19/09 at 12:30 AM. There was no documented nursing note as to why the Ativan was given. - A nursing note dated 5/19/09 at 2:00 AM, stated that Patient #27 was restless and IV Ativan was given. However, this was not documented on Patient #27's M.A.R. - Patient #27's M.A.R. and nursing notes dated	A 166		

STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 166	Continued From page 23 5/19/09 at 3:00 AM, stated that Patient #27 was restless and Haldol 10 mg was given. - A nursing note dated 5/19/09 at 5:00 AM, stated that Patient #27 was thrashing and needed two staff members to restrain him. The note documented that Ativan was given. However, this was not documented on Patient #27's M.A.R. - Patient #27's M.A.R. and nursing notes dated 5/19/09 at 6:00 AM, stated that he was agitated. The note documented that Ativan was given. Patient #27's record documented he was physically and chemically restrained multiple times on 5/18/10 and 5/19/10. However, Patient #27's care plan was reviewed. The care plan had not been updated since 5/16/09 and it did not include the use of the chemical and physical restraints. Additionally, the hospital's "Patient Restraint Policy," revised on 6/05, was reviewed. The policy did not include direction to staff to modify the patient's plan of care should restrain use become necessary. The hospital's Compliance Officer was interviewed on 3/11/10 starting at 2:18 PM. He confirmed the policy was not current with the Federal CoPs and Patient #27's care plan was not updated. The hospital failed to ensure hospital staff incorporated restraint usage into Patient #27's plan of care.	A 166	A166 Completion date: 4/19/2010	
A 167	482.13(e)(4)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION	A 167	REFER TO TAB 3	

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A 167	Continued From page 24 [The use of restraint or seclusion must be--] (ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and hospital policies, it was determined the hospital failed to ensure safe and appropriate restraint techniques were defined by hospital policy. This affected the care of 1 of 1 patient (#27) who was restrained using physical and chemical restraints. This resulted in the lack of direction for staff on how to respond and how to keep patients safe while restraints were being implemented. Findings include: 1. Patient #27 was a 70-year-old male who had a left total knee arthroplasty on 5/15/09. A nursing note dated 5/18/09 at 6:22 AM, stated Patient #27 stated he could not breathe and took off his bi-pap. The patient was described as cussing at the staff, uncooperative, yanking tubing, trying to crawl out of bed over the side rails, and trying to hit staff. The note documented that a Code Green was called and at 6:25 AM, the patient was restrained on the floor by 8 staff members. Further review of the patient record documented that a Code Green was called again for Patient #27 on 5/18/09 at 6:58 AM. The nursing note stated Patient #27 continued to try to get out of bed and a second Code Green was called and the patient was assisted to the floor. The nurse documented that Patient #27 had possibly sustained an injury to his operative knee. The	A 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 167	Continued From page 25 5/18/09 6:25 AM Occurrence Report was reviewed. It stated a Code Green was required to restrain Patient #27 who subsequently sustained a possible knee injury during the situation. A hospital information sheet, undated, titled "Code Green Security" stated the following: "In the Event [sic] you need security or assistance in handling an abusive patient, family member or visitor - Push page button on the phone, and dial '4' - Page 'Code Green' and location 3 times - All available security/maintenance employees are to respond and will provide the required assistance" However, the hospital's "Patient Restraint Policy," revised on 6/05 did not describe what a Code Green was and did not direct staff on how to respond or react to a violent patient. This was confirmed by the hospital's Compliance Officer during an interview on 3/11/10 starting at 2:18 PM. The facility failed to ensure patient restraint policies were sufficiently developed to ensure staff implemented restraints in a safe manner. 2. Refer to A164 as it relates to the facility's failure to ensure restraint policies were sufficiently developed to ensure staff completed and documented comprehensive assessment information for restraint use. 3. Refer to A166 as it relates to the facility's failure to ensure restraint policies were sufficiently developed to ensure staff incorporated restraint usage into the patient care plans.	A 167		

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A 167	Continued From page 26 4. Refer to A168 as it relates to the facility's failure to ensure restraint policies were sufficiently developed to ensure staff had a complete physician's order for the physical restraints. 5. Refer to A169 as it relates to the facility's failure to ensure restraint policies were sufficiently developed to ensure chemical restraint orders were not written as PRN orders. 6. Refer to A178 as it relates to the facility's failure to ensure restraint policies were sufficiently developed to ensure patients were seen, face-to-face, by an appropriately qualified staff member within 1 hour of the initiation of restraint. The hospital failed to ensure the restraint policy was sufficiently developed to ensure safe and appropriate restraint techniques were implemented.	A 167		A167 Completion date; 4/19/2010
A 168	482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on review of medical records, policies and procedures, and interviews with staff, it was determined the hospital failed to ensure that 1 of 1 patient reviewed, (#27) for whom physical and chemical restraints were used, had a complete physician's order for the physical restraints. This	A 168	REFER TO TAB 3	

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A 168	Continued From page 27 resulted in the lack of appropriate physician oversight in the use of restraints. Findings include: 1. The hospital's "Patient Restraint Policy," revised on 6/05, stated "Upon initiation of restraints and [sic] obtain a verbal or written order as soon as possible, not to exceed 1 hour after initiation." However, Patient #27's record documented he was physically and chemically restrained without physician's orders as follows: a. Chemical restraints: A Physician's verbal order from Patient #27's Internal Medicine physician, dated 5/18/09 at 6:30 AM, stated that staff were to give Narcan 0.4 mg IV first, then Haldol 2 mg IV second, and then Ativan 1 mg IV. The order continued to direct nursing staff to give Ativan 1 mg, as needed, as often as needed, until the physician's arrival. Ativan 1 mg was given according to Patient #27's 5/18/09 M.A.R. at 6:50 AM. The nurse noted that a physician was in to see Patient # 27 at 6:55 AM. However, Patient #27's M.A.R. and nursing notes documented he continued to receive Ativan, after he was seen by the physician and without a renewal of the Ativan order as follows: - 5/18/09 at 8:20 AM: he was given Ativan 1 mg IVP. - 5/18/09 at 10:20 AM: he was given Ativan 1 mg IVP. - 5/18/09 at 10:30 AM: he was given Ativan 1 mg IVP. - 5/18/09 at 10:40 AM: he was given Ativan 1 mg IVP. - 5/18/09 at 11:00 AM: he was given Ativan 1 mg IVP. - 5/18/09 at 4:15 PM: he was given Ativan 1 mg	A 168		

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A 168	Continued From page 28 IVP. - 5/18/09 at 4:30 PM: he was given Ativan 1 mg IVP. - 5/18/09 at 7:55 PM: he was given Ativan 1 mg IVP. - 5/18/09 at 10:00 PM: he was given Ativan 1 mg IVP. - 5/18/09 at 11:00 PM: he was given Ativan 1 mg IVP. b. Physical restraints: - A nursing note dated 5/18/09 at 6:22 AM, stated Patient #27 stated he could not breathe and took off his bi-pap. The patient was described as cussing at the staff, uncooperative, yanking tubing, trying to crawl out of bed over the side rails, and trying to hit staff. The note documented that a Code Green was called and at 6:25 AM, the patient was physically restrained on the floor with 8 staff members. - On 5/18/09 at 8:03 AM, a nursing note stated Patient #27 continued to try to get out of bed and a second Code Green was called and the patient was assisted to the floor. - The 5/18/09 nursing notes documented at 4:30 PM, Patient #27 was restrained using a sheet. This required the assistance of 3 staff members to hold back Patient #27 "to prevent him from self harm." - A nursing note dated 5/19/09 at 5:00 AM, stated Patient #27 was thrashing and needed two staff members to hold him down. Patient #27's record did not include physician orders for any of the above listed restraints as required by the hospital's policy. The hospital's	A 168		

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A 168	Continued From page 29 Compliance Officer was interviewed on 3/11/10 starting at 2:18 PM. He confirmed the policy was not followed. The hospital failed to obtain orders for restraints.	A 168		A168 Completion date; 4/19/2010
A 169	482.13(e)(6) PATIENT RIGHTS: RESTRAINT OR SECLUSION Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN). This STANDARD is not met as evidenced by: Based on staff interview, review of medical records and hospital policies, it was determined the hospital failed to ensure restraint orders were not written as PRN orders for 1 of 1 patients (#27) for whom physical and chemical restraints were used. This resulted in the use of chemical restraints without consulting the physician, violation of patient rights, and had the potential to interfere with patient safety. Findings include: 1. Patient #27 was a 70-year-old male who had a left total knee arthroplasty on 5/15/09. His record documented PRN chemical restraints were ordered for Patient #27 as follows: a. A physician's verbal order dated 5/18/09 at 6:30 AM, direct nursing staff to give Ativan 1 mg as needed, as often as needed, until the physician's arrival. b. A physician's verbal order dated 5/18/09 at 8:40 AM, ordered Haldol IV/IM every 6 hours as needed for agitation. c. A physician's verbal order dated 5/18/09 at 5:00 PM, ordered the Haldol to be increased to 10	A 169	REFER TO TAB 3	

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A 169	Continued From page 30 mg IV/IM every 4 hours as needed for agitation. The hospital's "Patient Restraint Policy," revised 6/05, identified anxiolytics (Ativan) and antipsychotics (Haldol) as chemical restraints. However, the policy did not identify that PRN chemical restraint orders were not acceptable. The hospital's Compliance Officer was interviewed on 3/11/10 starting at 2:18 PM. He stated that chemical restraints were not to be ordered as PRN. The hospital failed to ensure restraint orders were not written as PRN orders.	A 169		A169 Completion date; 4/19/2010
A 178	482.13(e)(12) PATIENT RIGHTS: RESTRAINT OR SECLUSION When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1-hour after the initiation of the intervention -- o By a-- - Physician or other licensed independent practitioner; or - Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) of this section. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and hospital policy, the hospital failed to ensure 1 of 1 patient, (#27) who had restraints applied for the management of violent behavior, received a face-to-face evaluation by an appropriately qualified person within 1-hour after the initiation of the intervention. This resulted in	A 178	REFER TO TAB 3	

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A 178	Continued From page 31 the inability of the hospital to adequately assess patients for the causes of behaviors and treatment alternatives. Findings include: 1. The hospital's "Patient Restraint Policy," revised 6/05, identified anxiolytics (Ativan) and antipsychotics (Haldol) as chemical restraints. The policy stated a face to face evaluation of the patient restrained needed to be done only prior to each 24 hour renewal of the restraint order. The hospital's Compliance Officer was interviewed on 3/11/10 starting at 2:18 PM. He stated that it was assumed that patients who were restrained because of behavioral issues would receive a face-to-face evaluation by an appropriately qualified person within 1-hour after the initiation of the intervention. However, Patient #27's M.AR. and nursing notes documented multiple restraints without a face-to face evaluation by an appropriately qualified person within 1 hour of initiation of the restraint as follows: - 5/18/09 at 6:50 AM: he was given Ativan 1 mg. - 5/18/09 at 8:03 AM: a nursing note stated Patient #27 continued to try to get out of bed and was assisted to the floor. - 5/18/09 at 8:20 AM: he was given Ativan 1 mg IVP. A physician's verbal order, dated 5/18/09 at 8:40 AM, ordered Haldol IV/IM every 6 hours as needed for agitation. - 5/18/09 at 8:55 AM: he was given Haldol 5 mg IV. - 5/18/09 at 10:20 AM: he was given Ativan 1 mg IVP.	A 178		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 178	Continued From page 32 - 5/18/09 at 10:30 AM: he was given Ativan 1 mg IVP. - 5/18/09 at 10:40 AM: he was given Ativan 1 mg IVP. - 5/18/09 at 11:00 AM: he was given Ativan 1 mg IVP. - 5/18/09 at 4:15 PM: he was given Ativan 1 mg IVP. - 5/18/09 at 4:30 PM: he was given Ativan 1 mg IVP. His nursing note also documented Patient #27 was restrained by 3 staff members and staff used a "sheet" to prevent him from "self harm." A physician's verbal order dated 5/18/09 at 5:00 PM, instructed the Haldol to be increased to 10 mg IV/IM every 4 hours, as needed, for agitation. - 5/18/09 at 6:55 PM: he was given Haldol 10 mg IM. - 5/18/09 at 7:55 PM: he was given Ativan 1 mg IVP. - 5/18/09 at 10:00 PM: he was given Ativan 1 mg IVP. - 5/18/09 at 11:00 PM: he was given Ativan 1 mg IVP and Haldol 10 mg IVP. A physician's verbal order dated 5/18/09 at 11:30 PM, ordered Ativan 2 mg IV x 1. Patient #27's M.A.R. did not document that the nurse had followed the order. However, his M.A.R. and nursing notes documented he received the following: - 5/18/09 at 11:45 PM: he was given Ativan 1 mg IVP. - 5/19/09 at 12:30 AM: he was given Ativan 1 mg IVP. - 5/19/09 at 2:00 AM: he was given Ativan IVP. The dose was not documented.	A 178		

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A 178	Continued From page 33 - 5/19/09 at 3:00 AM: he was given Haldol 10 mg IM. - 5/19/09 at 5:00 AM: he was given Ativan. The dose he received was not documented. Additionally, his nursing note stated he was thrashing and needed two staff members to hold him down. - 5/19/09 at 6:00 AM: he was given Ativan 1 mg IVP. Patient #27's record did not include documentation of a face-to-face evaluation by an appropriately qualified person within 1-hour after the initiation of the intervention for any of the above listed restraints. The hospital's Compliance Officer was interviewed on 3/11/10 starting at 2:18 PM. He confirmed a face-to-face evaluation was not done for Patient #27. The hospital failed to ensure a face-to-face evaluation was performed by a qualified individual for patients who were restrained.	A 178		A178 Completion date: 4/19/2010
A 196	482.13(f)(1) PATIENT RIGHTS: RESTRAINT OR SECLUSION Training intervals. Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion- (i) Before performing any of the actions specified in this paragraph; (ii) As part of orientation; and (iii) Subsequently on a periodic basis consistent with hospital policy. This STANDARD is not met as evidenced by:	A 196	REFER TO TAB 3	

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A 196	Continued From page 34 Based on staff interview and review of hospital policies, patient records and personnel restraint training records, it was determined the hospital failed to ensure 100% of their direct care staff demonstrate competency with restraint application. This directly impacted 1 of 1 patient (#27) reviewed, who was restrained by staff members and had the potential to compromise the quality and safety of patient care. Findings include: 1. Patient #27 was a 70-year-old male who had a left total knee arthroplasty on 5/15/09. A nursing note dated 5/18/09 at 6:22 AM, stated Patient #27 stated he could not breathe and took off his bi-pap. The patient was described as cussing at the staff, uncooperative, yanking tubing, trying to crawl out of bed over the side rails, and trying to hit staff. The note documented that a Code Green was called and at 6:25 AM, the patient was restrained on the floor by 8 staff members. Further review of the patient record documented that a Code Green was called again for Patient #27 on 5/18/09 at 6:58 AM. The nursing note stated Patient #27 continued to try to get out of bed and a second Code Green was called and the patient was assisted to the floor. The nurse documented that Patient #27 had possibly sustained an injury to his operative knee. The 5/18/09 6:25 AM Occurrence Report was reviewed. It stated a Code Green was required to restrain Patient #27 who subsequently sustained a possible knee injury during the situation. A hospital information sheet, undated, titled "Code Green Security" stated the following:	A 196		

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A 196	Continued From page 35 "In the Event [sic] you need security or assistance in handling an abusive patient, family member or visitor - Push page button on the phone, and dial '4' - Page 'Code Green' and location 3 times - All available security/maintenance employees are to respond and will provide the required assistance" However, the hospital's "Patient Restraint Policy," revised on 6/05 did not describe what a Code Green was and did not direct staff on how to respond or react to a violent patient. This was confirmed by the hospital's Compliance Officer during an interview on 3/11/10 starting at 2:18 PM. The hospital's "Patient Restraint Policy," stated "When clinically indicated, the restraint procedure is implemented by an RN who is trained in restraint technique upon a physician's/licensed independent practitioner order." The hospital's Compliance Officer was interviewed on 3/12/10 starting at 8:33 AM. He stated that all direct care staff are trained in the application of restraints yearly using the Health Stream on-line educational system. The Health Stream on-line course was reviewed. The course did not include the following: - A description of what a Code Green. - What a comprehensive restraint assessment included. - Directions to staff on how patient care plans were to be modified when restraint was used. - Training on the prohibition of PRN chemical restraint orders. - Training on the required face-to-face evaluation	A 196	REFER TO TAB 3 CODE GREEN POLICY REFER TO TAB 3 HEALTH STREAM COURSE CODE GREEN POLICY FOR CODE GREEN DRILLS	

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A 196	Continued From page 36 of the patient restrained, by a qualified staff member with in 1 hour of the initiation of the restraint. The hospital's Compliance Officer was interviewed on 3/12/10 starting at 8:33 AM and confirmed the course was a general overview of restraint use. The Post-Surgical Supervisor was interviewed on 3/12/10 starting at 9:52 AM. She stated that she and her staff had not been trained beyond the Health Stream on-line course for restraint usage. When asked about restraint response she stated she did not know to modify the patient's plan of care, a comprehensive restraint assessment needed to be done, or that and a face-to-face assessment needed to be completed within 1 hour for patients who were restrained due to behavioral issues. She stated that she and the other staff had not been trained on how staff were to respond and react to a Code Green and that she had never been required to demonstrate her competency with restraint application. A Surgical Unit CNA was interviewed on 3/12/10 starting at 10:07 AM. He stated he had worked at the hospital over the last 5 years. He stated he had not been trained beyond the Health Stream on-line course for restraint usage. When asked what a Code Green meant he could not provide an answer. He stated he had not been trained on how he was to respond and react to a Code Green and had never been required to demonstrate his competency with restraint application. A Surgical RN was interviewed on 3/12/10 starting at 10:30 AM. She stated she had been	A 196		

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A 196	Continued From page 37 working at the hospital for the last 2 years. She stated she had not been provided any restraint training beyond the Heath Stream on-line course. When asked, she could not recall what a Code Green was. When asked about restraint response she stated did not know how to modify the patient's plan of care, she did not know a comprehensive restraint assessment needed to be done, or that a face-to-face assessment needed to be done within 1 hour of a patient being restrained due to behavioral issues. She further stated she had not been required to competency with restraint application. The hospital failed to ensure restraint training was comprehensive and that all direct care staff could demonstrate competency with restraint application. 2. Refer to A207 as it relates to the facility's failure to ensure staff that provided staff restraint training were qualified to teach the course.	A 196	REFER TO TAB 3 POLICY: RESTRAINT SECTION UP DATING PLAN OF CARE A196 Completion date 4/19/2010	
A 207	482.13(f)(3) PATIENT RIGHTS: RESTRAINT OR SECLUSION Trainer requirements. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and personnel restraint training records, it was determined the hospital failed to ensure 1 of 1 staff, that provided staff restraint training was qualified to teach the course. This had the potential to compromise the quality and safety of patient care. Findings include:	A 207	REFER TO TAB 3 FORMAL TRAINING: RESTRAINT COORDINATOR ATTENDING FORMAL COURSE IN BOISE 4/19 - 4/22. WILL BE CERT AS A RESTRAINT TRAINER TEMORARY CMS APPROVED DVD	

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A 207	Continued From page 38 1. The hospital's Compliance Officer was interviewed on 3/12/10 starting at 8:33 AM. He stated the Post-Surgical Supervisor, who no longer worked at the facility, had provided a training class on restraints to employees. Review of her file revealed she had no documented training that qualified her. Her record did not contain any evidence of continued education, expanded training, and/or experience in techniques used to address patients' behaviors and the use of restraints. This was confirmed by the hospital's Compliance Officer on 3/12/10 starting at 8:33 AM. The hospital failed to ensure staff that provided restraint training were qualified to teach the course.	A 207		A207 Completion date 4/19/2010 4/22/2010
A 267	482.21(a)(2) QAPI QUALITY INDICATORS The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital services and operations. This STANDARD is not met as evidenced by: Based on staff interviews, review of medical records, hospital policies, and quality assurance documents, it was determined the hospital failed to fully identify internal systematic problems related to the medical care of 1 of 1 patient (#27) reviewed, who was restrained. This resulted in missed opportunities for the hospital to analyze and intervene with troubled patient care areas. Findings include: 1. Patient #27 was a 70-year-old male who had a left total knee arthroplasty on 5/15/09.	A 267	REFER TO TAB 3 RESTRAINT PLAN QUALITY MEASURES	

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A 267	Continued From page 39 A nursing note dated 5/18/09 at 6:22 AM, stated Patient #27 stated he could not breathe and took off his bi-pap. The patient was described as cussing at the staff, uncooperative, yanking tubing, trying to crawl out of bed over the side rails, and trying to hit staff. The note documented that a Code Green was called and at 6:25 AM, the patient was restrained on the floor by 8 staff members. The note stated that at 6:27 AM, the physician was told of the incident and chemical restraint orders (Ativan and Haldol) were obtained. A Physician's verbal order from Patient #27's Internal Medicine physician, dated 5/18/09 at 6:30 AM, stated that staff were to give Narcan 0.4 mg IV first, then Haldol 2 mg IV second, and then Ativan 1 mg IV. The order continued to direct nursing staff to give Ativan 1 mg, as needed, as often as needed until the physician's arrival. Ativan 1 mg was given according to Patient #27's 5/18/09 M.A.R. at 6:50 AM. The nurse noted that a physician was in to see Patient # 27 at 6:55 AM. However, Patient #27's M.A.R. and nursing notes documented he continued to be physically and chemically restrained, including receiving excessive Ativan as follows: - 5/18/09 at 8:03 AM: a nursing note stated Patient #27 continued to try to get out of bed and was assisted to the floor. - 5/18/09 at 8:20 AM: he was given Ativan 1 mg IVP. A physician's verbal order, dated 5/18/09 at 8:40 AM, ordered Haldol IV/IM every 6 hours as needed for agitation.	A 267		

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A 267	Continued From page 40 - 5/18/09 at 8:55 AM: he was given Haldol 5 mg IV. - 5/18/09 at 10:20 AM: he was given Ativan 1 mg IVP. - 5/18/09 at 10:30 AM: he was given Ativan 1 mg IVP. - 5/18/09 at 10:40 AM: he was given Ativan 1 mg IVP. - 5/18/09 at 11:00 AM: he was given Ativan 1 mg IVP. - 5/18/09 at 4:15 PM: he was given Ativan 1 mg IVP. - 5/18/09 at 4:30 PM: he was given Ativan 1 mg IVP. His nursing note also documented Patient #27 was restrained by 3 staff members and staff used a "sheet" to prevent him from "self harm." A physician's verbal order dated 5/18/09 at 5:00 PM, instructed the Haldol to be increased to 10 mg IV/IM every 4 hours, as needed, for agitation. - 5/18/09 at 6:55 PM: he was given Haldol 10 mg IM. - 5/18/09 at 7:55 PM: he was given Ativan 1 mg IVP. - 5/18/09 at 10:00 PM: he was given Ativan 1 mg IVP. - 5/18/09 at 11:00 PM: he was given Ativan 1 mg IVP and Haldol 10 mg IVP. A physician's verbal order dated 5/18/09 at 11:30 PM, ordered Ativan 2 mg IV x 1. Patient #27's M.A.R. did not document that the nurse had followed the order. However, his MAR and nursing notes documented he received the following: - 5/18/09 at 11:45 PM: he was given Ativan 1 mg IVP.	A 267		

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A 267	Continued From page 41 - 5/19/09 at 12:30 AM: he was given Ativan 1 mg IVP. - 5/19/09 at 2:00 AM: he was given Ativan IVP. The dose was not documented. - 5/19/09 at 3:00 AM: he was given Haldol 10 mg IM. - 5/19/09 at 5:00 AM: he was given Ativan. The dose he received was not documented. Additionally, his nursing note stated he was thrashing and needed two staff members to hold him down. - 5/19/09 at 6:00 AM: he was given Ativan 1 mg IVP. On 5/19/09 at 6:38 AM, Patient #27 was found unresponsive and pulseless. CPR was initiated and he was transferred to another hospital where he did not recover from the cardiac arrest and passed away on 5/24/09. Despite ongoing multiple physical and chemical restraints, Patient #27's record did not include documentation of a complete comprehensive restraint assessment, orders for the physical restraints and the on-going use of Ativan (from 6:55 AM to 11:30 PM on 5/18/09), chemical restraint orders which were not PRN orders or documentation that a face-to-face evaluation was performed by a qualified staff member within one hour of the initiation of restraints. Further, his care plan, dated 5/16/09, did not include the use of the chemical and physical restraints. Additionally, the hospital's "Patient Restraint Policy," revised on 6/05 did not define a safe and appropriate restraint and when asked about staff training, the hospital's Compliance Officer stated, during an interviewed on 3/12/10 starting at 8:33 AM., that all direct care staff were trained in the	A 267		

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A 267	Continued From page 42 application of restraints yearly using the Health Stream on-line educational system. However, the Health Stream on-line course was reviewed. The course did not include the following: - A description of what a Code Green was. - What a comprehensive restraint assessment included. - Directions to staff on how patient care plans were to be modified when restraint was used. - Training on the prohibition of PRN chemical restraint orders. - Training on the required face-to-face evaluation of the patient restrained, by a qualified staff member with in 1 hour of the initiation of the restraint. The hospital's Compliance Officer was interviewed on 3/12/10 starting at 8:33 AM and confirmed the course was a general overview of restraint use. When asked about staff who provided training on restraint use, the hospital's Compliance Officer stated the Post-Surgical Supervisor, who no longer worked at the facility, had provided a training class on restraints to employees. However, when reviewed, her personal file did not include documentation to support that she was a qualified trainer. Her record did not contain any evidence of continued education, expanded training, and/or experience in techniques used to address patients' behaviors and the use of restraints. This was confirmed by the hospital's Compliance Officer. The hospital's undated "Framework For Root Cause Analysis and Action Plan," Hospital Peer Review, and Code Blue Team committee minutes for Patient #27 did not identify the following:	A 267		

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A 267	Continued From page 43 - Nursing staff did not have an ongoing order to give Ativan (from 6:55 AM to 11:30 PM on 5/18/09). - Patient #27 was chemically and physically restrained. - A complete comprehensive restraint assessment had not been completed for Patient #27. - His plan of care was not updated to incorporate restraint usage. - Hospital restraint policies did not define a safe and appropriate restraint. - The hospital failed to obtain orders for restraints. - The hospital failed to ensure restraint orders were not written as PRN orders. - The hospital failed to ensure 100% of their direct care staff demonstrated competency with restraint application. - The hospital failed to ensure a face-to-face evaluation was performed by a qualified individual. - The hospital failed to ensure staff who provided restraint training were qualified to teach the course. This was confirmed during an interview with the hospital's Compliance Officer during an interview on 3/12/10 starting at 8:33 AM. The hospital failed to fully identify internal systematic problems related restraint use.	A 267		A267 Completion date 4/19/2010
A 438	482.24(b) FORM AND RETENTION OF RECORDS The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The	A 438	REFER TO TAB 8 CHART AUDIT HISTORY & PHYSICAL AUDIT	

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A 438	Continued From page 44 hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. This STANDARD is not met as evidenced by: Based on medical record review, review of committee meeting minutes, policy review, and staff interview, it was determined the facility failed to ensure medial records contained complete documentation including appropriate dates, times, and signatures, and that all physician's orders were documented for 9 of 38 patients, (#1, #2, #5, #6, #15, #16, #17, #21, and #37) whose records were reviewed. Failure to ensure complete and accurate documentation had the potential impact coordination and care of patients. Findings include: 1. Patient #21 was a 6-day-old infant born in the facility on 3/04/10. He was originally admitted to the well baby nursery, but developed seizure-like activity and required respiratory support. He was admitted to the CCN on 3/06/10. Handwritten admitting orders, written and signed by the physician on 3/06/10 at 3:30 AM, included the initiation of the antibiotic Gentamicin 4 mg/kg intravenously every 24 hours. A subsequent telephone order from the physician was documented on 3/07/10 at 2:55 PM. This order was for a Gentamycin trough blood level to be drawn before every 3rd dose of medication. On the "3 Day M.A.R." form initiated on 3/04/10 for Patient #21, CCN nurses documented he was given his first dose of Gentamicin on 3/06/10 at 3:25 AM, his second dose on 3/07/10 at 3:30 AM, and his third dose on 3/08/10 at 3:35 AM. The medical record for Patient #21 also contained a	A 438	REFER TO TAB 8	

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A 438	Continued From page 46 Director of Surgical Services on 3/09/10 during an interview that started at 2:15 PM. 3. Patient #2 was a 55-year-old female who had a laparoscopic cholecystectomy on 3/08/10. Patient #2's Anesthesia Record, that included medications given and the monitoring of the patient, dated 3/08/10, was not signed by the person providing the anesthesia. This was confirmed by the hospital's Director of Surgical Services on 3/09/10 during an interview that started at 2:15 PM. 4. Patient #5 was a 74-year-old male who had a right shoulder arthroscopy on 3/08/10. His H&P, dated 2/22/10, was not timed or signed. This was confirmed by the hospital's Director of Surgical Services on 3/09/10 during an interview that started at 2:15 PM. 5. Patient #6 was a 63-year-old male who had a right knee arthroscopy on 3/08/10. Review of the hospital's 3/09/10 Patient Diets log documented Patient #6 was on a low sugar diet. Patient #6's record did not contain an order for the specialized diet. In addition, a "Nursing Note" dated 3/09/10 at 8:40 AM stated the nurse had received a verbal order to discontinue Patient #6's IV. However Patient #6's record did not contain a physician's verbal order for the discontinuation of Patient #6's IV on 3/09/10. The above missing orders were confirmed with Patient #6's primary nurse on 3/09/10 at 4:30 PM. 6. Patient #15 was a 74-year-old female who had a left total knee replacement on 3/09/10. Her	A 438		

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A 438	Continued From page 47 H&P was not dated, timed, or signed. This was confirmed by the hospital's Director of Surgical Services on 3/09/10 during an interview that started at 2:15 PM. 7. Patient #16 was a 69-year-old male who had a right total knee replacement on 3/09/10. Patient #16's Pre and Post Anesthesia Evaluation, dated 3/09/10, did not contain the times as to when the evaluations took place. This was confirmed by the hospital's Director of Surgical Services on 3/09/10 during an interview that started at 2:15 PM. 8. Patient #17 was a 79-year-old male who had a left shoulder arthroscopy on 3/09/10. Patient #17's record contained a Post-Anesthesia Evaluation that was not dated nor timed. Additionally, Patient #17's Pre-Anesthesia Orders were not dated nor timed. This was confirmed by the hospital's Director of Surgical Services on 3/09/10 during an interview that started at 2:15 PM. 9. Patient #37 was a 76-year-old female who had a plastic surgery procedure on 3/08/10. Her H&P was not dated nor timed. This was confirmed by the hospital's Director of Surgical Services on 3/09/10 during an interview that started at 2:15 PM. The hospital failed to ensure medical records were complete and accurate.	A 438		A438 Completion date: 4/19/2010
A 490	482.25 PHARMACEUTICAL SERVICES The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff	A 490	REER TO TAB 5	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 490	Continued From page 48 is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This CONDITION is not met as evidenced by: Based on review of medical records, review of policies and procedures, observation, and staff interview, it was determined the facility failed to ensure safe and secure drug dispensing and storage. Failure to ensure safe dispensing of medication and appropriate drug storage had the potential to impact patient safety and increased the risk for drug diversion. Findings include: 1. Refer to A491 as it relates to the facility's failure to ensure pharmacy maintained control of distribution of sample medications for patients and the failure to properly approve an off-label use of medication. 2. Refer to A500 as it relates to the facility's failure to ensure patient safety with a pharmacist review of medication orders prior to administration to patients. 3. Refer to A502 as it relates to the facility's failure to ensure all drugs were stored in a secure location. 4. Refer to A503 as it relates to the facility's failure to ensure Schedule II, III, IV, and V drugs (controlled substances) were locked within a secure location. 5. Refer to A505 as it relates to the facility's failure to ensure outdated medication was not available for use.	A 490	REFER TO TAB 5 SAMPLE MEDICATION POLICY REFER TO TAB 5 "MEDICATION, STORAGE INSPECTION AND REVIEW REFER TO TAB 5 CONTROLLED SUBSTANCE MANAGEMENT #2312 REFER TO TAB 5 "MEDICATION STORAGE INSPECTION AND REVIEW" & PLAN OF CORRECTION.	

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A 490	Continued From page 49 The cumulative effect of these deficient systemic practices prevented the facility from ensuring supervision of dispensing and storage of medications throughout the facility.	A 490		
A 491	482.25(a) PHARMACY ADMINISTRATION The pharmacy or drug storage area must be administered in accordance with accepted professional principles. This STANDARD is not met as evidenced by: Based on observations, interviews, and review of medical records it was determined the facility failed to ensure accepted professional standards were followed for the receipt and dispensation of sample drugs [and the administration of drugs during off-label use]. These failures impacted 2 of 2 outpatient clinics, who distributed patient samples [and 4 of 4 patients (#28, #29, #30 and #31) reviewed, whose records documented off label use of medication during surgery]. These failures had the potential to result in inadequate pharmacy control in the case of recalled or missing medications and the potential to impact quality of care and patient safety. Findings include: 1. The Director of Nursing for Redi Care provided a tour of the Redi Care on Columbus, on 3/10/10 beginning at 3:00 PM. Based on observations there were 12 medications readily available as patient samples. The Director of Nursing stated the facility did not maintain a record of the sample medications supplied or distributed, including lot numbers and expiration dates. The facility did not have a system in place to readily identify who was given which sample medications. 2. During a tour of the Taylor Crossing Redi Care	A 491		

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A 491	Continued From page 50 on 3/11/10 at 9:30 AM, a cabinet of 4 sample medications was noted. The Office Manager for this Redi Care was present during the tour and stated the facility did not have a process in place for monitoring the samples received or distributed at the clinic, including lot numbers and expiration dates. They did not have a way to track which medication samples were supplied to which patients. The hospital failed to ensure the pharmacy adequately maintained control of all medications supplied and distributed through the Redi Care Clinics. 3. The records of Patients #28 - #31 were reviewed. The records documented they were all given Haldol 1 mg IV during their individual surgical procedures. FDA web site information for Haloperidol , provided by the facility on 3/11/10, included Labeled Indications as schizophrenia, control of tics and vocal utterances of Tourette's disorder in children and adults and severe behavioral problems in children. Unlabeled or Investigational uses included emergency sedation of severely-agitated or delirious patients and use as an antiemetic. The FDA had not approved Haldol for surgical procedures. The Director of Pharmacy was interviewed on 3/12/10 at 12:26 PM. She confirmed that Haldol was being ordered and given intravenously presurgical. She also verified that the use Haldol intravenously was an off-label use of the medication and should be approved by the Pharmacy and Therapeutics Committee. She	A 491	REFER TO TAB 5	

STATEMENT OF DEFICIENCIES 'D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 491	Continued From page 51 stated that the use of Haldol was not approved by the Pharmacy and Therapeutics Committee. The hospital failed to ensure that the off-label use of Haldol was approved by the Pharmacy and Therapeutics Committee.	A 491		A491 Completion date; 4/19/2010
A 500	482.25(b) DELIVERY OF DRUGS In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the facility failed to ensure patient safety with a pharmacist review of medication orders prior to administration to patients for 2 of 37 patients (#18 and #21) whose records were reviewed. Failure to have a pharmacist review medication orders prior to administration (except in emergency situations) had the potential to lead to adverse drug reactions and medication errors. Findings include: 1. Patient #21 was a 6-day-old infant born in the facility on 3/04/10. He was originally admitted to the well baby nursery, but developed seizure-like activity and required respiratory support. He was admitted to the CCN on 3/06/10. Hand-written admitting orders, written and signed by the physician on 3/06/10 at 3:30 AM, included the antibiotics ampicillin 100 mg/kg IV every 12 hours and gentamicin 4 mg/kg IV every 24 hours. Patient #21's medical record contained a document titled "3 Day M.A.R." The dates on the M.A.R. were 3/04/10, 3/06/10, 3/07/10, and	A 500	REFER TO TAB 5	

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A 500	Continued From page 52 3/08/10. Times of the administration of medications would be documented in the appropriately dated column. The form contained a list of several pre-printed medications routinely given to infants, such as erythromycin ophthalmic ointment and hepatitis B vaccine. The ampicillin and gentamicin orders were hand-written in. Another "3 Day M.A.R." was found with the dates 3/09/10 and 3/10/10. Again, the ampicillin and gentamicin were hand-written in. The process for completing the M.A.R. for the Perinatal Department was discussed with the Director of Pharmacy on 3/12/10 beginning at 11:40 AM. She stated the Perinatal Departments utilized a pre-printed M.A.R. with common medications specific to each department (i.e. Labor & Delivery and Nursery) already listed. Additional medications administered would then be added by hand. The order for the medication was to be faxed to pharmacy where it would be reviewed and added on a computer-generated M.A.R. The computer-generated M.A.R. would then be available for placement in the patient's chart. She stated that medication orders from the Perinatal Departments are not always faxed down. The Director of Pharmacy reviewed Patient #21's M.A.R. from 3/04/10 through 3/10/10. She stated it did not appear that pharmacy was aware of the addition of the ampicillin and gentamicin to Patient #21's medication regime as these medications were still hand-written on the second M.A.R. for the dates 3/09/10 and 3/10/10. 2. Patient #18 was a 67-year-old female who had a cystoscopy with placement of lighted stents on 3/09/10. Patient #18 had a history of diabetes and was on insulin. On 3/09/10 at 6:17 PM, nursing took a verbal order from Patient #18's	A 500		

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A 500	Continued From page 53 primary physician for insulin. The order was written as below: Regular insulin, sliding scale 4 times a day as follows: 200-250 5 units 250-300 8 units 300-350 10 units greater then 350 call physician. Patient #18's M.A.R. reflected the above orders, and nursing was administrating the insulin as above. On 3/10/10 at 2:35 PM, Patient #18's primary nurse was interviewed. When asked, the nurse as to how much insulin would be given for a blood sugar of 250 (i.e. 5 or 8 units) due to the conflicting order. Similarly, the nurse did not know how much insulin would be given for a blood sugar of 300 (8 or 10 units) or for 350 (10 units or none) due to the conflicting order. On 3/10/10 at 2:35 PM, the Director of Pharmacy was interviewed. She was shown the insulin order and she stated that her department did not have the order on file. The facility failed to ensure all medication orders were reviewed by pharmacy staff prior to administration.	A 500	REFER TO TAB 5 "SAMPLE OF NEW P & T APPROVED SLIDING SCALE	A500 Completion date; 4/19/2010
A 502	482.25(b)(2)(i) SECURE STORAGE All drugs and biologicals must be kept in a secure area, and locked when appropriate. This STANDARD is not met as evidenced by: Based on observations and interviews, it was	A 502	REFER TO TAB 5	

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A 502	Continued From page 54 determined the hospital failed to ensure all drugs were stored in a secure location in 6 of 9 departments (Nursery, PACU, Surgical Unit, Labor and Delivery, Post-Surgical Unit, and the Redi Care on Columbia) observed, with medications requiring storage. Failure to ensure medications were kept secure affected all patients, visitors, and staff in these locations and increased the risk of the diversion of medications. Findings include: 1. During an observation of the Nursery Department on 3/09/10 beginning at 11:50 AM, it was noted that routine medications, such as antibiotics, were stored in a drawer at the back of the nursery. Additional medications, such as Hepatitis B vaccine, were stored in a refrigerator in the isolation room. This room was separated from the main nursery behind a closed door. During an observation on 3/09/10 at approximately 3:15 PM, it was noted that the drawer of stored medications was located behind a curtain which had been pulled closed for patient and family privacy. Neither the drawer of medication, nor the refrigerator, was in a secure location and able to be monitored at all times. 2. The Director of Nursing for Redi Care provided a tour of the Redi Care Clinic on Columbia on 3/10/10 beginning at 3:00 PM. During the tour an unlocked cabinet was found containing respiratory medications such as Duoneb, Pulmicort/Xopenex, and Albuterol. These medications were available to auxiliary staff and patients. When asked, Director of Nursing for Redi Care stated she did not know that the medications needed to be secured.	A 502	REFER TO TAB 5 PLAN OF CORRECTION REFER TO TAB 5 PLAN FOR CORRECTION MEDICATION HAVE BEEN MOVED TO ONE CABINET WITH LOCK REFER TO TAB 5 "MEDICATION STORAGE" POLICY WITH PLAN EDUCATION	

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A 502	Continued From page 55 3. During a tour of the hospital's Surgical Unit on 3/08/10 from 1:43 PM to 3:00 PM, medications were observed to be unsecured and available to auxiliary staff as follows: a. Operating Room #8, a 3/4 full bottle of Chlorhexidine Gluconate 0.12% (mouth wash) was observed on a cart and available to auxiliary staff. b. The anesthesia storage closet contained a bottle of Dyclonine 1% in bacteriostatic sodium chloride (a local anesthetic) that was on a shelf and available to auxiliary staff. c. An anesthesia cart, located in the surgical hall, had 2 labeled prefilled syringes on the top of the cart and available to auxiliary staff. The Anesthesiologist was not working that day. d. A medication cart in the hall of the surgical suite was observed to be unlocked. The cart contained medications which included, but were not limited to dexamethasone, cyanocobalamin, trichloracetic, heparin, silver nitrate, estrace, vasopressin, ciplodex, Kenalog, indigocarnmine, xylocaine, lidocaine, bupivacaine with epinephrine, epinephrine, and antibiotics that were available to auxiliary staff. The Director of Surgical Services was interviewed during the observations. She stated that she only thought that medications needed to be secure from patients and not auxiliary staff. 4. During a tour of the hospital's PACU on 3/08/10 from 3:30 PM to 3:45 PM, medications were observed to be unsecured and available to	A 502	REFER TO TAB 5 "MEDICATION STORAGE" STAFF ORIENTATION TO POLICY STAFF EDUCATION TO NEED TO LOCK CARTS TAB 1 "LETTER TO ANES PROVIDER"	

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A 502	Continued From page 56 auxiliary staff as follows: a. A cabinet in the PACU was observed to be unlocked. The cabinet contained medications that included, but were not limited to Lasix, dexamethasone, Benadryl, Robinul, Flexeril, Reglan, and Phenergan that were available to auxiliary staff. During the tour a PACU nurse was questioned about the medications. She stated that 6 nurses were working on the unit and the cabinet had only 2 keys to unlock it. She stated that it should be locked at all times. The facility failed to ensure all medications were stored in a secure location. B. Refer to A503 as it relates to the facility's failure to ensure Schedule II, III, IV, and V drugs (controlled substances) were locked within a secure area on the PACU, Surgical Unit, Labor and Delivery Unit, Post-Surgical Unit, and the Redi Care on Columbia.	A 502		A502 completion date; 4/19/2010
A 503	482.25(b)(2)(ii) CONTROLLED DRUGS KEPT LOCKED Drugs listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 must be kept locked within a secure area. This STANDARD is not met as evidenced by: Based on observations, interviews, and review of policy, it was determined the hospital failed to ensure Schedule II, III, IV, and V drugs (controlled substances) were locked within a secure area in 5 of 9 departments (PACU, Surgical Unit, Labor and Delivery Unit, Post-Surgical Unit, and the	A 503	REFER TO TAB 5	

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A 503	Continued From page 57 Redi Care on Columbia) observed, with medications requiring storage. Failure to ensure these medications were locked and secure had the potential to affect all patients, visitors, or staff in these areas and increased the risk of diversion of these medications. Findings include: 1. The hospital's policy, "Controlled Substance Management," approved 10/02, was reviewed. According to the policy, controlled substances were to be kept in a secure double locked cabinet which was kept locked except when in active use. During observations of the facility, controlled substances were not observed to be locked as follows: a. On 3/09/10 from 9:21 to 10:43 AM, an anesthesia cart was observed to be left unlocked in the hallway of the Labor & Delivery Department. The cart contained controlled substances which included but were not limited to Fentanyl, a Schedule II medication and Promethazine, a Schedule V medication. At 10:40 AM, Staff A, the CRNA who was working in Labor & Delivery that day, returned to the cart while the surveyor checked for expired medications. He acknowledged that he had left his cart unsecured while he obtained supplies to restock it. Additionally, on 3/10/10 at 10:35 AM, an anesthesia cart was again observed left unlocked in the hallway of the Labor & Delivery Department. In an interview on 3/10/10 at 10:35 AM, the CNA at the front desk stated that Staff B was the CRNA assisting laboring patients that day. b. The Post-Surgery Supervisor provided a tour	A 503	REFER TO TAB 5 "CONTROLLED SUBSTANCE POLICY" STAFF EDUCATION EQUIPMENT CHANGE TO COMBINATION LOCKS	

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A 503	Continued From page 58 of the Post-Surgical Department on 3/10/10 from 9:00 AM to 9:45 AM. During the tour it was noted medication were stored in a box with a lock. However, the box of medications was found to be unlocked during the tour. The box contained controlled substances which included, but were not limited to Fentanyl, Demerol, Dilaudid, and Hydrocodone, all Schedule II drugs. During the tour the Post-Surgery Supervisor confirmed the medications should be secure. c. The Director of Nursing for Redi Care provided a tour of the Redi Care on Columbia on 3/10/10 beginning at 3:00 PM. During the tour it was discovered that narcotic medications including, but not limited to Demerol, a Schedule II drug were not double locked. e. During a tour of the hospital's Surgical Unit on 3/08/10 from 1:43 PM to 3:00 PM, topical cocaine, a Schedule II drug, was observed to not be double locked in the anesthesia storage closet. The Director of Surgical Services was interviewed during the observation. She confirmed the topical cocaine was not double locked. f. During a tour of the hospital's PACU on 3/08/10 from 3:30 PM to 3:45 PM, it was noted that controlled substances were not secured. Medications were stored in a box, in an open cabinet with a lock in place. However, the cabinet was unlocked. The medications contained in the box, included but were not limited to, Morphine Sulfate, Dilaudid, Fentanyl, Demerol, Hydrocodone, all Schedule II drugs. During the observations a PACU nurse was	A 503		

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A 503	Continued From page 59 questioned about the medications. She stated that 6 nurses were working on the unit and the cabinet had only 2 keys to unlock it. She stated that the narcotics should be double locked at all times. The hospital failed to ensure all controlled substances were double locked.	A 503		A503 Completion date: 4/19/2010
A 505	482.25(b)(3) UNUSABLE DRUGS NOT USED Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use. This STANDARD is not met as evidenced by: Based on observations, staff interviews, and review of policies , it was determined the hospital failed to ensure outdated medication was not available for use in 3 of 9 departments (Labor and Delivery, Post-Surgical, and PACU) observed, supplying medications for patient use. Expired medications still accessible for patient use had the potential to impact the effectiveness of the medication therapy. Findings include: 1. The hospital's "MEDICATION STORAGE, INSPECTION AND REVIEW" policy, revised 6/17/09, was reviewed. It documented that expired medications would not be available for use. However, expired medications were observed to be available for use as follows: a. On 3/08/10, beginning at 2:00 PM, a tour of the Labor & Delivery rooms was conducted. In Labor Room 1 an ampule of Narcan with an expiration date of 11/09 was found. The Director of Inpatient Services verified this outdated medication at the time of the observation.	A 505	REFER TO TAB 5 REFER TO TAB 5 PLAN ALL DEPARTMENT WILL GRANT PHARMACY ACCESS FOR THE PURPOSE OF INSPECTING MEDICATION EXPIRATION	

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A 505	Continued From page 60 2. On 3/09/10 at 10:40 AM, during a medication check of the anesthesia cart found in the hallway of the Labor & Delivery Department, a vial of atracurium with an expiration date of 9/09 was found. Staff A, the CRNA utilizing the cart verified the expired medication at the time of the observation. 3. The Post-Surgery Supervisor provided a tour of the Post-Surgical Department on 3/10/10 from 9:00 AM to 9:45 AM. During observation of the medication supply in the medication room, a Nicotine Transdermal patch which expired on 12/09 but was still available for patient use was noted. The Post-Surgery Supervisor verified the outdated medication at the time of the tour and removed the medication. 4. During a tour of the hospital's PACU on 3/08/10 from 3:30 PM to 3:45 PM, 3 Bisacodyl suppositories which expired on 6/08 were in circulation for patient use. During the tour the Director of Surgical Services confirmed the medications were expired and disposed of them. The hospital failed to ensure outdated medications were not available for patient use.	A 505	REFER TO TAB 5	A505 completion date; 4/19/2010
A 536	482.26(b)(1) SAFETY FOR PATIENTS AND PERSONNEL Proper safety precautions must be maintained against radiation hazards. This includes adequate shielding for patients, personnel, and facilities, as well as appropriate storage, use and disposal of radioactive materials. This STANDARD is not met as evidenced by: Based on policy review, interview, and	A 536	REFER TO TAB 6 PLAN RADIOLOGY TRAINING AND EQUIPMENT PURCHASE WITH CCN STAFF MONITORING OCCURRENCE REPORT FOR TRENDING AND RESPONSE	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 536	Continued From page 61 observation, it was determined the hospital failed to ensure proper safety precautions were utilized for 3 of 3 staff, (C, D, and F) and 1 of 1 patient (#38) observed during an x-ray. Failure to utilize proper lead shields left individuals exposed to unnecessary radiation. Findings include: Patient #38 was a 2-hour-old infant born via scheduled Cesarean section on 3/09/10. He was observed in a radiant warmer in the nursery from 3:24 PM to 3:40 PM. During this time, Staff C, the radiology technician, arrived to obtain a chest x-ray. At 3:40 PM, he returned to re-take the chest x-ray. Patient #38 was not provided with a lead gonad protection shield during either x-ray. In addition Staff D and F, RNs who were assisting with the x-ray, and Staff C, the radiology technician, were not wearing a lead shield and were exposed to the x-ray radiation. The lead shield was hung over the arm of the x-ray machine. The hospital's policy titled "Portable Radiology Procedures in CCN," approved 10/02, was reviewed. It was documented in sections 2.3 and 2.4, under "Procedure," that the infant's reproductive organs would be shielded, and personnel around the infant would wear protective shields. Staff E, a CCN RN, was interviewed on 3/09/10 at 11:50 AM. She stated the radiology technicians occasionally need to be reminded to place gonad shields on the infants. The facility failed to ensure proper safety precautions were utilized during an x-ray.	A 536	REFER TO TAB 6 POLICY PORTABLE RADIOLOGY STAFF EDUCATION WITH STAFF MONITOR ING	A536 completion date; 4/19/2010
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE	A 724	REFER TO TAB 6 PLAN OF CORRECTION	

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A 724	Continued From page 62 Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observations and staff interviews it was determined the hospital failed to ensure laboratory blood sampling collection equipment, which was available for patient testing, had not expired for 2 of 2 outpatient clinics. Additionally, the hospital failed to ensure that staff performed quality control tests on blood testing equipment for 1 of 2 outpatient clinics. The use of expired laboratory sample collection equipment and not performing quality control tests on blood testing equipment had the potential to result in incorrect laboratory results. Findings include: 1. During a facility tour of the hospital's Columbia Redi Care on 3/10/10 starting at 8:18 AM, the following expired blood collection laboratory equipment was observed: a. Four-hundred and ninety 10 ml purple top tubes that had expired on 1/10. b. One 5 ml purple top tube that had expired on 12/09. c. Three 5 ml yellow top tubes that had expired on 1/10. d. Two 5 ml green top tubes that had expired on 11/09. The Columbia Crossing Redi Care Laboratory Technician was interviewed on 3/10/10 starting at 9:10 AM. He stated the above items were	A 724	REFER TO TAB 6 POLICY " LAB ISTAT QC" MONITOR WILL BE DONE BY LAB DEPARTMENT MANAGER RESULTS WILL BE REVIEW BY LAB QA COMMITTEE REFER TO TAB 6 POLICY " LAB TUBE EXPIRATION" MONTHLY CHECK WILL BE PERFORMED LAB DEPARTMENT MANAGER WILL PERFORM MONTHLY CHECK FOR TEST TUBE EXPIRATION, STAFF EDCUATION VIA MAN DATORY READ E-MAIL AND STAFF MEETINGS	

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A 724	Continued From page 63 expired and removed them out of circulation. 2. During the tour the clinics I-STAT was observed. This piece of equipment tests blood chemistry levels such as sodium, potassium and chloride. The Columbia Redi Care procedure, that was not dated, stated each day staff were to run quality controls. This was not done for 1/19 to 2/7/10, 2/9, 2/11, 2/13, 2/15 to 2/27/10, 3/1, 3/4, 3/7, and 3/9/10 per the printed I-STAT QA testing results. The Columbia Crossing Redi Care Laboratory Technician was interviewed on 3/10/10 starting at 9:10 AM. He stated that he has talked to the other Laboratory Technicians about doing the quality checks in the past and will continue to get them to be compliant with the daily checks. 3. During a facility tour of the hospital's Taylor Crossing Redi Care on 3/11/10 starting at 8:18 AM, the following expired blood collection laboratory equipment was observed: a. A bag full (50 plus) pediatric purple top tubes that had expired on 2/10. b. One 10 ml purple top tube that had expired on 1/10. The Taylor Crossing Redi Care Laboratory Technician was interviewed on 3/11/10 starting at 8:30 AM. She stated the above items were expired and removed them. The hospital failed to ensure supplies and equipment were maintained to ensure an acceptable level of quality.	A 724	REFER TO TAB 6	A724 Completion date: 4/19/2010
A 747	482.42 INFECTION CONTROL	A 747	REFER TO TAB 7	

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A 747	Continued From page 64 The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observations, review of policies, and staff interviews, it was determined the hospital failed to provide a sanitary environment and promote safe practices to avoid sources and transmission of potential infection in 7 of 10 departments toured, and for 1 of 2 patients, (#38) whose care was observed. This failure had the potential to affect all staff and patients working or receiving care in the facility. Failure to ensure proper infection control processes had the potential to impact the health of patients and staff. Findings include: 1. Patient #38 was a 2-hour-old infant born via scheduled Cesarean section on 3/09/10. She was observed in a radiant warmer in the nursery from 3:24 PM to 3:40 PM. During this time Staff F, the primary CCN RN for Patient #38, was seen collecting blood via a venous puncture and attempting to start an IV line. Staff F was not wearing gloves when working with Patient #38, a newborn who had not been bathed. Staff D, another CCN RN assisting with the blood collection, was also observed not wearing gloves while handling Patient #38. At 3:32 PM, Staff D left Patient #38's warmer and went to check on a nursing mother who was behind a curtain. Within minutes Staff D returned to Patient #38's bedside and continued assisting	A 747	REFER TO TAB 7 PLAN OF CORRECTION WITH CS POLICY FOR BOTH REDI-CARE'S AND MVH CS DEPARTMENT.	

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A 747	Continued From page 65 with blood collection and starting the IV line. She was not observed to wash her hands or use alcohol based hand rub, while providing care between patients. Between 3:24 PM and 3:32 PM, Staff C, a radiology technician, entered the CCN to obtain a chest x-ray on Patient #38. He was observed assisting in positioning Patient #38 onto the film for the x-ray. He did not wear gloves, wash his hands, or use alcohol based hand rub, before or after obtaining the x-ray. Staff C returned at 3:40 PM to retake the chest x-ray. He did not wash his hands upon entering or leaving the nursery. The hospital's Labor & Delivery Department policy, "Hand Washing in the Perinatal Unit," approved 6/24/09, was reviewed. The policy documented that gloves should be worn when touching any body substances. It also documented, "Antimicrobial hand washing products should be used before invasive procedures, before and after direct patient contact in the nurseries..." In addition, the policy documented that hand washing was indicated between contacts with different patients. The Perinatal Supervisor was present in the CCN during the observation on 3/09/10, and was interviewed on 3/10/10 at 11:20 AM. She explained that gloves are part of the standard precautions taken with every patient. They were to be used for exposure to blood and body fluids, including handling a newborn before its first bath. She also stated she expected staff to wash their hands before and after procedures, before contact with infants, and between cares for different infants. She stated ancillary staff entering the CCN were expected to wash their	A 747		

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A 747	Continued From page 66 hands. She explained that Staff C did not wash his hands upon entering the CCN for the retake of the x-ray because he did not touch Patient #38. The facility failed to ensure proper gloving and hand washing techniques were used to care for Patient #38. 2. A tour of the Nursery Department was conducted on 3/08/10 at approximately 2:30 PM. It was noted that the scale used to weigh infant diapers was located inside the isolation room. The door to the isolation room was closed. Staff E was the CCN RN on shift during the tour and she was interviewed on 3/08/10 at 2:35 PM regarding the process used to weigh an infant diaper. She explained the diaper was changed with gloved hands then carried to the scale in the isolation room. She acknowledged that the door to the isolation room remained closed much of the time and to get to the scale the door would be opened with gloves which had been used to change a diaper. The facility failed to ensure the process for weighing an infant's diaper did not generate a source of contamination in the nursery. 3. Staff H, a surgical technician for Cesarean sections in the Labor & Delivery Department, was interviewed on 3/09/10 at 11:03 AM. She explained the process for doing the initial cleaning of surgical instruments used during Cesarean sections. She stated most of the time she used an enzymatic cleaner called Cleanzine. However, on 3/09/10 when she went to re-supply the stock in Labor & Delivery, Cleanzine was not available and she was told to use Prolystica instead. She explained that she was unsure of the specific	A 747	REFER TO TAB 7 PLAN WITH STAFF TRAINING BY CS SUPERVISOR	

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A 747	Continued From page 67 dilution recommendation for either cleanser, but filled her sink with water and then added 5-6 pumps of the cleanser. The facility failed to ensure detergents, used to clean medical instruments, were diluted in accordance with the manufacturer's recommendation. 4. The hospital's outpatient Redi Care Clinic on Columbia was toured on 3/10/10 starting at 3:00 PM. The hospital's second outpatient Redi Care Clinic at Taylor Crossing was toured on 3/11/10 starting at 9:00 AM. It was noted that in 2 outpatient clinics, instruments used for patient care and exams were washed, sterilized and autoclaved. The 2006 American National Standard for biological indicators for autoclaving, stated "Biological indicators should be used...for routine sterilizer efficacy monitoring at least weekly, but preferably every day that the sterilizer is in use." A biological indicator (spore test) is a devise used to monitor the sterilization process of the autoclave. It consists of a standardized population of bacterial spores. Biological indicators monitor the autoclaving cycle and ensure that all the parameters necessary for sterilization are present during the autoclaving process. Neither clinic used biological indicators to ensure autoclaved loads were accurate. The clinics did use a chemical indicator with each load that was autoclaved. However, without the use of weekly biological indicators, in conjunction with the chemical indicators, the clinics could not ensure that the parameters necessary for sterilization were met.	A 747	REFER TO TAB 7	

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A 747	Continued From page 68 Additionally, over 1/2 of instruments that were autoclaved in the two clinics did not have any identification as to when they were ran and who ran the load. This could result in the inability to recall contaminated instruments. Further, the clinics did not have a sterilizer standards information log, that would include; the lot number, the specific contents of the lot or load, including quantity, department, and specific description of the items, the exposure time and temperature if not provided on the sterilizer recording chart, and the name and initials of the operator. The deficient practices were confirmed by the Director on Nursing of the Redi Care Clinics on 3/10/10 at 3:15 PM and the Office Manager of the Taylor Crossing Redi Care Clinic on 3/11/10 at 9:30 AM. The hospital's Compliance Officer was interviewed on 3/11/10 starting at 8:18 AM. He stated that the hospital did not have policies for biological testing. The hospital's Director of Public Relations and Government Affairs, who is also over the outpatient clinics stated on 3/11/10 at 11:15 PM that he was unaware of any policies for biological testing. The hospital failed to ensure effective infection control monitoring of the autoclaving process for sterilizing instruments at the 2 outpatient clinics. 5. During a tour of the PACU on 3/08/10 starting at 3:30 PM, and during a tour of the Post Surgical unit on 3/10/10 starting at 9:00 AM, the	A 747		

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A 747	Continued From page 69 emergency crash carts were inspected. Both carts had a Yankauer suction catheter (a rigid suction tip used to suction fluids from patients' mouths or other cavities that contain fluids) that was connected to other tubing leading up to a small suctioning device. The Yankauer suction catheter and the tubing were hanging off the cart, unwrapped and exposed to potential contaminants. The Yankauer suction catheters were removed by staff and thrown out at the time of the tour. On 3/10/10 at 9:10 AM, the Post Surgical Supervisor stated that her unit had done a mock code and the cart had not been cleaned up since that time. The hospital failed to ensure patient care equipment was stored to ensure effective infection control. 6. The hospital's surgical suites were toured on 3/08/10 from 1:43 PM to 3:45 PM. Rooms 2, 4, and 5 were noted to have many tears in the linoleum. For example, room 2 had more than 50 one inch to three inch splits in the linoleum from equipment being moved across the floor. The Director of Surgical Services stated during the observations that housekeeping did a good job ensuring the floors were clean. However, when asked, she did not know how housekeeping ensured that blood, fluids, tissues, and dirt was cleaned out of each individual split in the floor. Additionally, a stool in Room 8 was observed to have tape on the top of the seat. This tape was used to reduce the slickness of the stool. However, the tape could not be sanitized and cleaned thoroughly. The hospital failed to ensure its surgical unit was	A 747		

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A 747	Continued From page 70 maintained to ensure effective infection control. 7. The hospital's surgical unit was toured on 3/08/10 from 1:43 PM to 3:45 PM. An anesthesiologist was observed in the hall talking on his cell phone with his gloves on. After the phone call he placed the phone in its holder on his waist and returned to the surgical suite where a patient was being operated on. The anesthesiologist did not change gloves, wash his hands, or clean the phone before he returned to patient care. A housekeeper was observed carrying a large bag of trash down the surgical hall, with gloves on after she had cleaned a dirty surgical suite. The housekeeper's cell phone rang and she answered it without taking off her gloves and washing her hands. After the call was completed, she placed the phone in her pocket. The Director of Surgical Services was asked during the observations if the unit had a cell phone policy. She stated no. The hospital failed to ensure its surgical unit staff used cells phones appropriately to practice effective infection control. 8. The hospital's surgical unit was toured on 3/08/10 from 1:43 PM to 3:45 PM. During the tour 3 anesthesia medication carts were observed. In the carts it was noted that used multi-dose medication vials were being stored with unopened and clean multi-dose medication vials. During the observation, the Director of Surgical Services was asked how they ensured that cross contamination did not occur with the medications. She stated they could not ensure that this would not happen.	A 747		

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A 747	Continued From page 71 The hospital failed to ensure its surgical unit's medications were stored to promote effective infection control. 9. The hospital's Central Supply unit was toured on 3/08/10 from 3:10 PM to 3:25 PM. Central Supply is a department on the surgical unit. Central Supply cleans the instruments that were used during the surgical procedure. During the tour a large sink containing water, detergent and instruments was observed. The Central Supply Technician was interviewed on the dilution of the detergent to the water. He stated the he puts in a few squirts of detergent and fills the sink half way. The instructions on the "Select Plus" detergent stated that the dilution ratio was to be 2 ounces of detergent to 1 gallon of water. The Central Supply Technician could not ensure that he had been diluting the detergent per the manufacturer's recommendations. 10. The hospital's Out-Patient Wound Clinic unit was toured on 3/11/10 from 10:10 AM to 11:03 AM. During the tour each exam room contained buckets that contained water, detergent and instruments. A Wound Clinic LPN was interviewed on the dilution of the detergent to the water. She stated the she puts in a "squirt" of detergent and fills the bucket half way. The instructions on the "Select Plus" detergent stated that the dilution ratio was to be 2 ounces of detergent to 1 gallon of water. The Wound Clinic LPN could not ensure that she had been diluting the detergent per the manufacturer's recommendations. The hospital failed to ensure detergents, used to clean medical instruments, were diluted per the manufacturer's recommendations.	A 747		

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A 747	Continued From page 72 11. The hospital's Out-Patient Wound Clinic unit was toured on 3/11/10 from 10:10 AM to 11:03 AM. During the tour a refrigerator, with patient medications in it, was observed in the IV Therapy Room. Also in the refrigerator were staffs personal drinks. The refrigerator contained an open can of Coke, a cup of coffee, and 2 opened bottles of water. When asked, during the tour, the Wound Clinic's Manager stated that the drinks should not have been there. The hospital failed to provide a sanitary environment and promote safe practices and avoid sources and transmission of potential infections.	A 747		A747 Completion date 4/19/2010
A 952	482.51(b)(1) HISTORY AND PHYSICAL Prior to surgery or a procedure requiring anesthesia services and except in the case of emergencies: (i) A medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration. (ii) An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration when the medical history and physical examination are completed within 30 days before admission or registration. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and hospital policies, it was determined the hospital failed to ensure medical history and	A 952	REFER TO TAB 8 HISTORY AND PHYSICAL PLAN OF CORRECTION	

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A 952	Continued From page 73 physicals were reviewed and updated prior to patient's surgeries for 8 of 12 patients, (#2, #4 - #6, #15, #16, #18 and #37) whose surgical medical records were reviewed. This resulted in the potential for surgical complications due to a lack of information regarding the patients' current heath conditions. Findings include: 1. The hospital's "HISTORY AND PHYSICAL MEDICAL POLICY," dated 6/31/09, stated when patients are admitted to the hospital an admission H&P included, "An appropriate assessment, to include a physical examination of the patient to update any components of the patient's current medical status that may have changed since the prior H&P or to address any areas where more current data is needed. This updated assessment should be recorded in the admission progress note or on the original H&P document." However, the policy was not implemented as follows: a. Patient #2 was a 55-year-old female who had a laparoscopic cholecystectomy on 3/08/10. Her H&P, dated 3/01/10 at 12:51 PM, stated Patient #2 had a history of bladder problems, abdominal pain, and nausea. The record contained no documented evidence that the surgeon had reassessed Patient #2's health status before the surgery. b. Patient #4 was a 77-year-old male who had a repair on his left middle finger on 3/08/10. His H&P, dated 2/28/10 at 10:20 AM, stated Patient #4 had a history of heart disease, hypertension, and thyroid issues. The record contained no documented evidence that the surgeon had reassessed Patient #4's health status before the surgery.	A 952		

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A 952	Continued From page 74 c. Patient #5 was a 74-year-old male who had a right shoulder arthroscopy on 3/08/10. His H&P, dated 2/22/10 untimed and not signed, stated Patient #5 had a history of cancer and stomach/bowel problems. The record contained no documented evidence that the surgeon had reassessed Patient #5's health status before the surgery. d. Patient #6 was a 63-year-old male who had a right knee arthroscopy on 3/08/10. His H&P, that was not dated or timed, stated Patient #6 had a history of diabetes and arthritis problems. The record contained no documented evidence that the surgeon had reassessed Patient #6's health status before the surgery. e. Patient #15 was a 74-year-old female who had a left total knee replacement on 3/09/10. Her H&P, that was not dated, timed or signed, stated Patient #15 had a history of hypertension and had a stroke in the past. The record contained no documented evidence that the surgeon had reassessed Patient #15's health status before the surgery. f. Patient #16 was a 69-year-old male who had a right total knee replacement on 3/09/10. His H&P, dated 10/21/09 that was untimed, stated Patient #16 had a history of benign prostate hypertrophy and arthritis. The record contained no documented evidence that the surgeon had reassessed Patient #16's health status before the surgery. g. Patient #18 was a 67-year-old female who had a cystoscopy with placement of lighted stents on 3/09/10. Her H&P, dated 2/22/10 that was	A 952		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130065	A. BUILDING _____ B. WING _____	03/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HOSPITAL	2325 CORONADO STREET IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 952	Continued From page 75 untimed, stated Patient #18 had a history of diabetes and thrombophlebitis. The record contained no documented evidence that the surgeon had reassessed Patient #18's health status before the surgery. h. Patient #37 was a 76-year-old female who had a plastic surgery procedure on 3/08/10. Her H&P, that was not dated or timed, stated Patient #37 had a history of liver disease arthritis and thyroid issues. The record contained no documented evidence that the surgeon had reassessed Patient #37's health status before the surgery. The hospital's Compliance Officer was interviewed on 3/12/10 starting at 2:30 PM. He confirmed the policy was not followed for the above patients. The hospital failed to ensure patients' medical H&Ps were reviewed and updated prior to their surgery.	A 952		A952 Completion date; 4/19/2010

4-22-10 Patricia reviewed & approved. TH

PLAN OF CORRECTION AMENDMENT 4/16/2010
Mountain View Hospital

TAG NUMBER	Description of how the actions will improve the processes that led to the deficiency cited	Responsible Personnel
records	3. **A952** H&P revision will enable patient to receive an assessment prior to every procedure. This change in process will improve patient safety by documenting any changes since	
A 490 Pharmaceutical Services	Following process improvement in regarding pharmaceutical service: 1. **A491** Medication process of administration, when used in an Off-Label use, will be reviewed and approved by the P&T committee. This process change will ensure safe delivery of medication to all MVH patients. Medication will be audited by the pharmacy department for off label use. P&T will also review and make recommendation regarding medication sampling management. This process improvement will designate a process for sampling accountability. 2. **A500** Medication will be reviewed by either the pharmacist or charge nurse (after hours) prior to use. This process will always be reviewed by the pharmacist when medications are used for chemical restraint. This process improvement will allow the RN to have a resource and a double check of the medication prior to administration. 3. **A502 & A503** A new device was implemented that allows cabinets to automatically lock when closed. This process Improvement will assist the nurse in maintaining a secure environment for medication while being available for administration of medication. This process improvement involved every provider. We have established a process where you own your medication until delivered, administered or stored properly.	Pharmacy Manager
A490 continues	4. **A505** All medication will be monitored for expiration date by the pharmacy department. This process failure was the result of a department monitoring their own medications. The improvement is to have one department check all medication for expiration date and proper management.	Pharmacy Manager
A536 Safety for patients and personnel "Radiation Exposure"	1. **A536** The radiology department was not properly implementing shield use for patient and staff members. This process improvement will reduce staff and patient exposure by properly training staff and with ongoing monitoring of the radiology department. The Radiology department has also purchased additional shields in order to have more available for staff and patient use.	Radiology Manager
A724 Facilities supplies	1. **A724** Staff education on the need for quality assurance with lab testing equipment. This process improvement	Lab Manager

PLAN OF CORRECTION AMENDMENT 4/16/2010
Mountain View Hospital

TAG NUMBER	Description of how the actions will improve the processes that led to the deficiency cited	Responsible Personnel
A043 Governing body	The governing body receives reports regarding the hospital improvement processes. This will enable the body to give direction and input with the plan of correction.	Compliance Officer
A115, A131 Patient rights	This process change will improve the patient awareness of the individuals that are providing care and services to the patient. Name all individuals on informed consent.	Compliance Officer
A144 Patient rights care in safe settings	Environmental monitoring by Pharmacy, Operative Nurses, Engineering, Housekeeping, Restraint Coordinator and the Compliance department along with staff education regarding the potential harmful exposure of patients. This correction will develop a team prevention process.	Safety Officer, Pharmacy Manager, Compliance Officer
A164 Patient rights restraint or seclusion	This process improvement will enable MVH to implement an approved CMS restraint process that will allow staff member to receive the appropriate training and a formally trained Restraint Coordinator to oversee the program.	Restraint Coordinator
A166	Staff education on the appropriate documentation of updating the plan of care as it relates to restraints.	Restraint Coordinator
A167	Staff education on how to properly apply restraints. This will be done on a didactical training program.	Restraint Coordinator
A168, A169	Training for staff to understand the physician order's for restraints. This process will improve staff education and confidence regarding patient restraint issues related to physician ordering process. Process is to empower the RN to know what is and what is not an acceptable order for restraints.	Restraint Coordinator
A178	This process will ensure restraint implementation is performed correctly by providing a face to face evaluation.	Restraint Coordinator
A196, A207	Our Restraint Coordinator with formal training will have the appropriate and required training to instruct staff members as to how the restraints are to be applied and what type we should use. Along with education on alternatives to restraints, this will provide a safe application of restraints to our patients.	Restraint Coordinator
A267 Quality Indicators	1. MVH restraint use is minimal. This allows the Safety committee to review all restraint use. The Restraint Coordinator will present each case when a restraint has been used for the committee to review and make recommendations for improvement. Having an Occurrence report generated every time a restraint is used will initiate the process.	Compliance Officer
A267 Quality Indicators A438 Form and retention of	2. Medical records are reviewed both opened and closed. This process change will allow for author education on deficiencies cited and other areas of medical record documentation. All chart errors will be reviewed by both individuals and the department with errors in charting. This data will be presented at QA committee.	Peri –op nursing manager.

LABOR AND DELIVERY WITH CCN
STAFF MEETING MINUTES

March 17 1700-1900 March 18 0730-0930

AWHOON Update Class March 29th 1000 to noon April 1st 1700 to 1900 Please all labor nurses attend! Very interesting updates to be presented and to document by!!

Dietary Consults available upon request! Call Sherri in dietary- know of the need or order and she will contact Anna Long the dietician.
An informative web address www.nutritioncaremanual.org password is diet
Anna can be reached by email along@mvhospital.net

Casey Jackman Clarification of radiologic issues. See emails included at end of minutes. NSR Reading Center 1-866-241-6635 or 1-866-329-4295

Dr Soucie Dr made a statement to Lisa that his group have been very well received here at MVH and that the care his patients receive has been great! Thanks for your efforts- everyone is noticing!

Dr Christensen also made comments how well he feels his patients are treated and the great care they receive! KUDOS to all!

Bonus Update Linda went over the criteria and the current percentage. Discussion about Volume and how the criteria was choosen by administration. Staff meeting attendance should make if good turn out in March. Volume – need more volume! Education CNA's to finish, nurses to finish scrub then should get the 1.5% there. Made a huge decrease in cost of supplies per patient for the .5% Everyone is doing so well- Thanks so much to those that have stepped up their game and making a concerted effort as an individual and to support your coworkers! I see a change and it is exciting!

New Policy Please see handout on Policy number 1008 Communication Via E-Mail

Pharmacy- please fax down orders on all meds and IV fluids for the CCN on a regular basis to 557-2860 Especially on Friday. Do more often when there have been more CCN babies. Pharmacy can not be accessed for routine stocking on the weekend or any other time. Kelly will now check nsy and labor rooms for outdated meds on a regular basis

Education-

Hand washing Everyone has been assigned this module as a component of State inspection. Deficits were found throughout the hospital. WASH Wash and Wash again! Remind others to do the same as well as ancillary staff!

Mandatory certifications- get updates to Wendy when ever you take a class or recert

IStat – mandatory for all as soon as possible. Take some time on your shift (Yes this has been hard of late) to have another confident staff member show you the proper technique and pass you off. Sheet will be in front of educational folder!

CCN drills- learning a lot, some very good conversations, observations and productive changes! Some new found items-Tape on the floor in the nsy to remind everyone to wash and gown. Found there is more space in the first warmer for in-depth resuscitation and multiple personnel than in the back CCN bed where the supplies are- go figure. More people need and want to locate supplies in the nsy. Need to remember the paperwork too. Need good communication for charting and division of labor and responsibility. The MD's want to be called sooner rather than later- if low 5 min apgar call and let them know! Please see reviews by email for complete details!

Chart Reviews- Ned or Lorri may ask you to review a past mom or baby chart for completeness of charting and details. Make a practice of looking at your own charts this way and it is amazing the different perspective you get! Sally and Roz doing labor chart reviews soon. Ask them and in person or in email if you have charting questions. Remember that after delivery- chart 1 hr recovery in the computer only then move the paper chart and chart all info and temps.

Patient Education

Purple Crying Video- please view for yourself at work. Very informative for the nurse and patient. This is a State of Idaho grant project. About 2$ per patient and then take home the video and pamphlet. It is really a neat program and such a worthy educational cause. We need to complete the application and obtain community sponsorship in order to proceed.

Mother/Baby Cares- this is another video I had but is now lost! Please help me locate this! I also want to provide the patients with this educational video upon discharge. I need the info on the cover to find out about ordering etc!

State/Federal Visit March 8-12

Charting and documentation- Orders not signed off, CCN orders not in chart, discharge paperwork not signed by nurse (feeding logs and teaching sheet). Babies not charted on Q 2 hrs. Yellow assessment sheet not signed. Charting protocols not followed. Chart temps Q 2hrs for ROM.

Baby scales that weight diapers needs to be located in the main nursery not in the isolation room.

Consents in Spanish- the main admissions desk will be getting hospital consents in Spanish and L/D will be getting surgical consents in Spanish.

Instrument soaking and cleaning- Everyone needs to be soaking the instruments in the same way and with the same dilution of enzyme, for approximately the same amount of time. Cathy has investigated this and the bottle is now labeled with the instructions. Please read and follow. Soak for a short time only and place new label on new bottle when old one is empty and discarded.

Hand washing everywhere- Inspectors observed a lack of hand washing throughout the hospital. Nursery- between babies, postpartum between moms, during procedures, use of cell phones before and after patient care and with gloves on. Ancillary staff coming in and not following procedures to the nursery and L/D. Housekeeping, anesthesia, radiology, lab. If you notice a breech please speak up! You are asked to complete a Hand washing module in Healthstream in the next 2 weeks to refresh your memory!!

Cell phones- too many cell phones were ringing as the State Inspector sat at the desk and in the nsy. Loud rings and some inappropriate ring tones.

Policies and Procedures- need to update policies and procedures to match actual practice.

Consents for procedures on babies and adults- LP consent not signed on baby, will need specific anes consent for epidurals or spinals in the future.

Newborn orders- NICU orders not on charts

Meds not locked-will add new turn lock on newborn meds now in the CCN main room to limit access to visitors in the nsy.

Outdated blood tubes up to 2 yrs in the IV trays.

Outdated meds In the labor rooms and CCN. Pharmacy will now be checking foe the out dated meds in these areas. Please check the equipment and supplies for expiration dates. This would include all supplies in the L/D

IV container, the meds in that room, the bedadine and hibiclens need to be labeled, and anything else we use on a patient needs to be labeled.

Locks-Keep all med cabinets in the labor rooms locked and the meds double locked- Please remember to turn the dial and change the numbers.

Occupational Health –Tina Ackerman Are you up on your shots?? Tina is sending out emails to Linda who will pass onto you. Each person has 2 weeks to complete any deficits under the occupational health guidelines.

Paperwork- The following paperwork is not getting completed!

Midnight census- Please charge nurse and CNA make sure this gets completed.

Acuities- Please remember to do every four hours.

Charting please be consistent, chart what you do, collaborate with multidisciplinary team members if needed, document change in status but also document the improvement in the status!, document equipment used and personnel present, note the time of events. **5 rights of med administration.**

Charges- Please use new form and guide for charges. Intensive first hour labor levels no longer exist. Complete right after delivery. Please store your strips as well. Recently quite a few have been returned for incomplete charges.

24hr chart checks on night shift-Please make this a routine for your personal practice. Check orders, MARS, labs etc sign and date at the bottom in read.

Check list before DC- double check when tearing down chart to make sure all is complete and stickered and charged for.

Pt D/C- Discharge patient out of computer on time-shortly after discharge as possible

Schedule Issues

Holiday schedule- Handed out for discussion. Question on Holidays that fall on the weekend but are celebrated on a different day than occur on the calendar. July 4th is on a Sunday this year. The hospital will pay for working on the Sunday. Decision forthcoming about when the individual will be scheduled- the actual holiday, the day celebrated or both.

Vacation coverage- Will cover 2 scheduled weekends per year for the individual if it falls during a planned vacation time. Need to be scheduled in advance in the purple request off book. Please do not request every weekend off.

Minor Holiday schedule- There was a request for a minor holiday rotation that include Mother's Day and Father's Day.

Daily Logs
Not getting done consistently- NSE, temp (warmer and fridge), CPSI log- admissions and discharges. State observed the voids in our logs as well.

New Logs

Induction Log- will come soon to track many details of the induced patient and the outcome.

Hugs Tag Log-too many are getting lost. We have 13 now and 3 more to come. Log out when placed on the infant after bath. Log out when infant is discharged. Please check pockets and change your scrubs prior to leaving for home.

Discharge info to care providers-Brandi has made up a "log". Please fill out when every baby goes home-ask for it in the nsy. This info is faxed to the MDs nightly. This way we do not receive calls all the time from the peds for a baby's screen, bili, wt, hearing, results all through the day and have to call Med Records.

Sick Calls 5 per year considered excessive. Please be aware of the commitment you have made to the hospital and your coworkers. Plan on being here when scheduled. Make all necessary arrangements ahead of time and have a back up plan if needed.

Please do trade slips. Please fill these out consistently. Do not trade into overtime. Even if you want coverage for a brief period ask Lorri and charge nurse first.

CHECK EMAIL
Please remember to check your mail so you will be informed. All educational recert classes go through your email. Mandatory readsMissed STABLE messages, learning opportunity, change in process.

Mandatory Reads

Discharges
Work together- nursery staff may not be able to do all the NSE's hearing screens, assessments...please work on getting the patient ready to go the night before and the discharge teaching completed. Give the purple teaching folder **at admission with instructions!**

Out-patient bilis All staff need to support this process. Nsy RN may or may not be able to accommodate. If you are not aware of the process in taking a sample and following up-please ask for assistance. One weekend there were 5 that did not get appropriate follow up until the evening- that is too late for any follow up care. Bilis can not wait until the end of the day for follow up.

Cord Blood sampling

The venous and arterial samples need to be run soon after collection. Place on ice until able to run. Nurses may not be able to pass through into the nsy window after c/s due to resuscitation efforts. Last time the sample was forgotten. Dr Leavitt will assist and draw his own. Dr Merrill and Dr Huggins will expect you to do it right away. I do not know the preference of other MDs.

C/S or Vag delivery- may need to save placenta and send. Leave clamp on in case more blood sampling is needed. When in doubt save in a placenta bucket.

Cell Phones Use of cell phones is upsetting your coworkers. Preventing individuals from doing appropriate patient care. Many complaints recently of a lot of talking, loud talking, inappropriate ring tones sounding in the nsy and at the L/D station, loud conversations, texting. Please leave these communications for break time only! Lorri now wants an email when this occurs with names, shift, and date. Charge nurses please take appropriate action and coworkers communicate to that person your frustration.

Rap Up Comments-Linda

Inspection was a positive because now we have motivation to become better. Inspectors stated there was a tremendous amount of improvement since 2006 The State has 10 working days to respond to us about deficits and corrections needed. MVH then has 30 days to respond and document improvements. State will come back and will talk again to the staff- want front line people to interview not managers. With all this in mind that has been mentioned regarding the state inspection – it is a huge opportunity to improve and make change where needed- use this momentum!!

Step up your game- Challenge your self to know every process and do not take short cuts. Take this opportunity if you do not know the process to refresh your current knowledge and learn the proper way! We have to all

get back to the basics of nursing- introductions, ID, review plan of care with MD and pt, review allergies and hx, review meds, chart at the bedside, teach, begin discharge teaching at the beginning, chart as you go, 5 rights of med admin, SBARR, etc. "Be on the ball" you know what is expected!

Thanks for coming and thanks for your participation!

Thank you for your comments about unit concerns and needs for education!

9.13. How to update and complete the patient's plan of care.

TRAINING FOR MEDICAL AND CHEMICAL RESTRAINTS

1. All restraint training is supervised by the restraint coordinator whom has completed a formal training program.
2. All RN/LPN staff will complete a mandatory training of restraints on Health stream upon hire and annually.
3. Physicians who order medical or chemical restraint shall be trained on the requirements of this policy and there shall be a review of all restraint orders by the Safety Committee.
4. All members expected to respond to a code green will receive training as it relates to their duties performed under this policy. Such training shall take place during new employee orientation and on a periodic basis as indicated by the results of quality monitoring activities.

ALL STAFF WILL BE TRAINED ON:

1. Techniques to identify patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint.
2. The use of non-physical intervention skills and techniques before restraint use.
3. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status condition.
4. The safe application and use of all types of restraint used by the staff member, including training in how to recognize and respond to signs of physical and psychological distress.
5. Recognizing signs of any incorrect application of restraints.
6. Identifying underlying causes of threatening behaviors exhibited by the patient and how staff can affect the behaviors.
7. Understanding and reviewing patient history.
8. De-escalation, mediation, self-protection techniques.
9. Recognizing age, developmental considerations, gender issues, ethnicity, language barriers, and the way the patient reacts to physical contact.

Staff members who apply restraints and monitor patients in restraints will receive training in:

- 9.1. Taking vital signs and interpreting their relevance to the physical safety of the patient in restraint.
- 9.2. Recognize nutritional and hydration needs.
- 9.3. Checking circulation and range of motion in the extremities.
- 9.4. Addressing hygiene and elimination.
- 9.5. Addressing physical and psychological status and comfort.
- 9.6. How to document and perform a face to face evaluation
- 9.7. Recognize readiness and helping patients meet behavior criteria for discontinuing restraint.
- 9.8. Recognize when to contact medically trained LIP services to evaluate and or treat the patient's physical status.
- 9.9. The application and removal of mechanical restraints.
- 9.10. Identify specific behavior changes that indicate the restraint is no longer necessary.
- 9.11. Use of MVH policy and obtaining physicians or LIP orders
- 9.12. Appropriate documentation of medical or chemical restraint use in the patient's medical record as appropriate.

3.4 For the purpose of the regulation, "reasonable to assume" includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.

3.5 Deaths must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death.

3.6 Staff must document in the patient's medical record the date and time the death was reported to CMS.

PATIENT/SIGNIFICANT OTHER EDUCATION

1. Teach:

1.1 Reason for application or use of restraint

1.2 Anticipated length of use

1.3 Safe method to obtain help/notify care provider of needs

1.4 Criteria for release i.e., "Patient Goals"

1.5 Care that will be provided to reassure patient/significant other (patient will be checked frequently, have his or her personal needs met, be released from restraints as quickly as possible).

SAFETY

1. Implement the following safety measures:

1.1 Apply restraint with room to insert on finger under the device; allow enough slack for the patient to move torso, pelvis, or extremity up to 2 inches.

1.2 Secure restraints to the parts of the bed that move with the patient. Never to the mattress or side rail.

1.3 Utilize appropriate number of staff (minimum of 2 people) and appropriate safety techniques whenever a restraint is released and during transfer of the patient to a safe environment

1.4 Remove potentially harmful items from the patient/patient care area (i.e., sharps, glass).

1.5 The mechanical restraint will be tied in an easy release method of just one loop to ensure quick release when the tail of the loop is pulled.

1.6 Release patient from all restraints in emergency situations, according to Mountain View Hospital evacuatio

GUIDELINES

1. Providing psychosocial comfort in patient with restraints

1.1 Communicating verbally with the patient

1.2 At least every 2 hours allowing the patient to have their hands free to communicate in sign language or by writing.

1.3 Telling the patient when you plan to return when leaving the room

1.4 Doing what you say you're going to do

1.5 Coming back frequently for nonverbal patients.

9.1 A safe method for patient to obtain help/notify care provider of needs.
9.2 Update plan of care which includes the restraint management.
9.3 The plan of care must include the time and date the restraint was initiated and why the restraint is being used as well as who performed the face to face evaluation.
9.4 Focus on elimination problem that caused need for restraints.
9.5 Intact, clean restraints by replacing them when soiled, broken or at risk for failure.
9.6 Communication with family/significant other (notify them promptly upon initiation of restraints in cases where the individual wants his and her family notified, and the family has agreed to be contacted).

10. Promote the following every 2 hours, and as needed

10.1 Psychosocial comfort.
10.2 Position changes and provide range of motion activities unless contraindicated by patient behavior, physical condition, clinician judgment
10.3 Nutrition, hydration, hygiene, and toileting.

11. Remove restraints when patient is no longer at risk or when alternatives are successful.
12. Document restraint use in the Restraint log on Post-Surgical floor. Notify Restraint Coordinator via e-mail, or file an occurrence report.

REPORTABLE CONDITIONS

1. Notify physician or licensed independent practitioner for any of the following:

1.1 Immediately if patient's condition is significant change from baseline.
1.2 Ineffectiveness of the restraint intervention
1.3 Dislodgement of lifesaving equipment
1.4 Functional decline
1.5 Complications of prolonged immobilization
1.6 Any injury to patient

2. Notify clinical leadership (unit manager or supervisor, Risk management, or Director of Nursing) of injury or death where it is reasonable to assume that it may be a result of restraint use.
3. The hospital must report to CMS each death:

3.1 that occurs while a patient is in restraint at MVH;
3.2 that occurs within 24 hours after the patient has been removed from restraint;
3.3 Known to the hospital that occurs within one week after restraint where it is reasonable to assume that use of restraint contributed directly or indirectly to a patient's death.

harm.

Situations in which restraints are clinically **justified**include:

1. The patient is harmful to self or others as evidenced by hitting, hair pulling, striking at or biting staff or family, and self-mutilation, and appropriate measures have been attempted.
2. The patient threatens placement and/or patency of necessary therapeutic lines/tubes, interfering with necessary medical treatment, and appropriate alternative measures have been attempted. Examples include self-removal of IV lines, NG tubes, ET tubes, Foley catheter, complex dressings, and picking at open wounds or incisions.
3. The patient is unable to follow directions to avoid self-injury, and appropriate protective, alternative measures and been attempted. Examples are climbing out of bed wandering in rooms or hallways without the strength or cognitive ability to safely do so.

Types of restraint devices available within MVH in order of less restrictive to more restrictive are:

1. Side rails when all 4 are raised to restrain the patient.
2. Arm splints not limiting, to allow line protection.
3. Mitts (1 or 2) allow fingers to move freely to protect lines; considered a restraint when tied down.
4. Vest restraint or lap belt; allows as much movement for the patient as possible.
5. Leather restraints are not a practice at Mountain View Hospital.

PATIENT CARE MANAGEMENT

1. A physician or LIP is responsible for ordering the use of a medical or chemical restraint. If restraints are needed, the physician or LIP will be contacted for a telephone order to initiate the restraints. A face to face evaluation by a qualified provider that has received the required training is required within 30 to 60 minutes of initiating the restraint.
2. RN will obtain a verbal or written order as soon as possible, not to exceed 30 minutes after initiation from an LIP.
3. An assessment will be done by the RN within **15 minutes** of the first application of the restraint then again in 1 hour then every 2 hours or as needed. A chemical restraint will also have a sedation level assessed every 1 hour, every time a dose of medication is given, and will be documented on the restraint flow sheet accordingly.
4. Document patient's education regarding restraint use, purpose, and goals.
5. If the use of a chemical restraint is required, the Pharmacist must verify that the chemical restraint is used within the pharmaceutical parameters approved by the FDA and/or reviewed by the Pharmacy and Therapeutics Committee for the indications that it is manufactured and labeled to address, including listing dosing parameters and that it follows the national practice standards recognized by the medical community.
6. If chemical restraint, the RN will notify the Pharmacist and document the name of the pharmacist contacted along with the date and time on the restraint flow sheet.
7. A physician or LIP will perform a physical evaluation of patient prior to each 24 hour renewal of a restraint order.
8. If a continued need for a restraint is clinically justified, a renewal of the original order will be given by the physician or LIP not to exceed 24 hours from the initial order time.
9. Maintain:

vital signs as appropriate and determine if less restrictive methods are possible.
5. Document patient education regarding restraint use and purpose.
6. Reassess and encourage release of restraints as soon as possible.
7. A restraint is never used for reasons of discipline or staff convenience.

Alternatives to the use of physical restraints may include:
1. Increased level of staff observation.
2. Distraction and/or redirection techniques.
3. Transfer to room in closer proximity to nurses' station.
4. Involve family in monitoring of patient.
5. Use of a sitter if appropriate.

Note that restraints are not intended as an intervention for patient fall prevention.
Persons will not be restrained in a prone position.
Management demonstrates its commitment to the aforementioned by providing and/or promoting:
1. Ongoing staff orientation and training.
2. Patient and family education, as appropriate.
3. The development and promotion of preventive strategies.

Note: This policy does not apply to devices used for positioning/securing, voluntary mechanical support (CPM) or those used by law enforcement officials,
although the standards of care stated within this document may be applicable.
Clinical Justification for use of restraints
When clinically indicated, the restraint procedure is implemented by an RN/LPN who is trained in restraint technique upon a physician/Licensed independent practitioner order. Unless there is an immediate and overriding concern for safety, the procedure is utilized only after a review of patient history and all alternatives including less restrictive treatment interventions have been tried without success.
The ordering physician or other LIP or a registered nurse (RN) trained in accordance with the requirements specified in the CoP (*see training section*
) must see the patient face-to-face within 1 hour after the initiation of the intervention and must document the following in the medical record:

1. The patient's immediate situation;

2. The patient's reaction to the intervention;

3. The patient's medical and behavioral condition; and

4. The need to continue or terminate the restraint.

Using the restraint flow sheet for patient behaviors and alternatives for use of restraints, clinical assessment, and utilization of restraint should be based on patient's behavior that may place the patient or others at risk for

condition. Chemical restraints may only be administered by a nurse who has training and knowledge in the safe and effective administration of the chemical restraint prescribed to include normal dose, maximum dose in 24 hours, side effects, interaction with the patient's other therapeutic medications. The pharmacist is available as a reference for the nurse's review as well as the Physician's Desk Refcrence prior to administration. If further clarification is required, the physician should be contacted for clarification. All orders for antipsychotics, sedatives (barbiturates and nonbarbitnates), tranquilizers, anxiolytics, and anesthetic general injectable medication require documentation of dose, route, frequency, and medical indication. The pharmacist or nurse prior to administration will clarify any orders that do not contain this information. The use of PRN or standing order drugs or medications is prohibited if used as a restraint.

8. **Attending Physician:** Any physician responsible for the care and treatment of the patient or his/her physician designee,. This includes a licensed independent practitioner (LIP), such as an advanced nurse practitioner.

POLICY

It is the policy of Mountain View Hospital to:

1. Prevent, reduce, and eliminate the use of restraints by:
   - 1.1 Preventing emergencies that have the potential to lead to the use of restraints.
   - 1.2 If an emergency exists, refer to the code green policy.
   - 1.3 Provide a physical assessment to identify medical problems that may be causing behavior changes in the patient such as elevated documented patient behavioral history, temperature, hypoxia, hypoglycemia, electrolyte imbalances, and drug interactions.
   - 1.4 Limit the use of restraints to emergencies where there is a risk of the patent harming him/her or others.
   - 1.5 Using the least restrictive method possible.

2. Protect the patient and preserve the patient's rights, dignity, and well-being during restraint use by:
   - 2.1 Respecting the patient as an individual.
   - 2.2 Maintaining a clean and safe environment.
   - 2.3 Encouraging the patient to continue to participate in own care.
   - 2.4 Maintaining the patient's modesty, preventing visibility to others, and maintaining a comfortable body temperature.

3. Provide for safe application and removal of the restraint by qualified staff. Discontinue as soon as possible based on an individualized patient assessment and re-evaluation.
4. Monitor and meet the patient's needs while in restraints at least every 2 hours including monitoring for signs and symptoms of injury, meeting nutrition and hydration needs, performing range of motion and circulation checks,

positioning, intravenous arm boards (not tied to the bed frame), radiotherapy procedures, protection of surgical and treatment sites in pediatric patients, etc.

3.1.2. Chemical/medication treatment of a documented mental/behavioral diagnosis and management of symptoms related to the diagnosis.

3.1.3. Adaptive support in response to assessed patient need (for example, postural support or orthopedic appliances that are released at the patient's request).

3.1.4. Age or developmentally appropriate protection such as strollers, safety belts, or high chair belts. Placement in a crib with raised rails is an age appropriate standard for infants and toddlers.

3.1.5. Measures taken to protect the patient from falling out of bed that are removed at the patient's request.

3.1.6. Helmets.

4. Non-restraint actions or devices may be used for safety purposes which may include but is not limited to:

4.1. Forensic and correction restrictions used for security by law enforcement officials.

4.2. Physical escorts with a light grasp to escort the patient to desired location if the patient can easily move away from the grasp.

4.3. If the patient requests assistance to be held still for an injection or a procedure to safely administer an injection or an intravenous line.

4.4. If a patient is on a bed that constantly moves to improve circulation or prevent skin breakdown and raised rails are a safety intervention to prevent the patient from falling.

4.5. When a patient is placed on seizure precautions and all side rails are raised and padded for their protection.

4.6. When a patient is being transported, evaluated, or treated on a narrow, elevated mobile stretcher and all side rails are raised.

5. **Medical Restraint:** is the restriction of a patient's movement for the management of a medically diagnosed condition in which the patient could be classified as irrational, uncooperative, interfering, or disrupting the efforts of the medical personnel to provide medical care for procedures (e.g., attempting to remove an endo tracheal tube, removing an IV line, pulling at Foley catheters, or NG tubes). The clinical assessment determines that these conditions are usually temporary and a result of the medical condition and the medical restraint is justified as an effort to preserve the well-being and condition of the patient. When medical restraints must be applied, it is to directly support medical healing.

6. **Seclusion:** is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. This type of restraint is not a practice of Mountain View Hospital.

7. **Chemical Restraint:** A medication used to control or to restrict the patient's freedom of movement and is **not** a standard treatment for the patient's medical or psychiatric/mental/behavioral diagnosed

	DEPARTMENT: Hospital Wide		CHAPTER:	
	POLICY: Restraints			
	APPROVED DATE: 4/16/2010	REVISED DATE: 4/16/2011	POLICY #: 1010	Page 1 of 9

Restraints may only be imposed to ensure the immediate physical safety of the patient and/or others to prevent harm.

Restraints use is considered an exceptional event and not a routine response to certain patient conditions or behaviors. Each patient will be assessed for their individual needs.

PURPOSE

Mountain View Hospital's goal is to use the minimal amount of restraints as possible to achieve the highest quality of safety for patient and medical staff. The use of restraints is an intervention implemented to prevent the patient from injuring himself/herself or from injuring others. Every effort is taken to protect patient rights, dignity and well-being at all times. This policy is used to provide consistent guidelines for the safe use of chemical and physical restraints if other alternatives, as determined by an interdisciplinary team, have prove clinically ineffective to provide a safe environment for the patient.

DEFINITIONS

1. **Alternative interventions**: Measures that modify the patient's environment, enhance interpersonal interaction, or provide treatment in order to minimize or eliminate the problem behaviors that place the patient at risk for injury to self or others.

2. **Restraint:** Any manual method, physical, chemical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his/ her arms, legs, body, or head freely. The types of restraint devices include: soft wrist restraints, hand mitts if tied down, vest restraints, and lap belts. Situations considered restraints are:

    2.1. Tucking sheets in tightly that prevent patient movement.

    2.2. Use of all four side rails for preventing patient from voluntarily getting out of bed.

    2.3. Recliners if the patient cannot easily remove the restraint appliance and get out on their own.

    2.4. Arm board if it is tied down or attached to the bed frame or the entire limb is immobilized so the patient cannot access his or her body.

    2.5. Physically holding a patient in a therapeutic hug

    2.6. Holding a patient down to give or administer a medication against the patients will.
    (This does not apply to pediatric patients for purpose of administering medication)

3. Some situations are **not** considered a restraint under this policy. Devices in this category can be easily removed by the patient; devices are age or developmentally appropriate; and medications may be used for the use of behavioral or mental disorders.

    3.1. Standard practices that are considered non-restraint methods include:

        3.1.1. Limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures and the related post procedure care processes (for example, snrgical

MOUNTAIN VIEW HOSPITAL

	DEPARTMENT: LAB		CHAPTER: POINT OF CARE	
	POLICY: I-STAT Policy			
	Author: Amanda Tinsley	Revised Date: 01/15/2010	Policy #:	Page 3 of 3

DAILY

Clean outside of I-STAT with alcohol pads.

MONTHLY

Print out electronic simulator report.

TWICE A YEAR

Every six months calibration needs to be performed.

AS NEEDED

Change batteries.

- On the screen, there will be a picture of the batteries. This shows that the batteries need to be changed.

Update the Software.

- A kit will come with new software. Just follow the instructions in the kit.

Authorization

_____ _____

Laboratory Manager Date

_____ _____

Laboratory Director Date

1. Put the electronic simulator in the cartridge slot.
2. The I-Stat will ask for your user ID twice. Enter your badge ID twice.
3. I-STAT will show on the screen a PASS or FAIL on the Electronic Stimulator Test.
4. If the I-STAT shows PASS, please document in I-STAT Q.C. log.
5. If the I-STAT shows FAIL, please test again. If you still receive a FAIL statement please call technical service at 1-800-366-8020.

SAMPLE PROCEDURE

1. Remove cartridge from fridge to bring to room temperature.
2. Order test (According to LabDAQ policy) in LabDAQ.
3. Collect sample from patient. Use either a syringe or draw sample directly into a DARK GREEN top tube.
4. If you use a syringe, activate safety device and take needle off of syringe. Discard needle into sharps container.
5. If you use a DARK GREEN top tube, open top of tube and use a transfer pipette to get blood.
6. Open cartridges, making sure not to touch gold connectors on the top of the cartridge, and place cartridges on a dry, clean, flat, hard surface.
7. Expel 1-2 drops into sharps container to ensure there is no air bubbles in syringe or transfer pipette.
8. Place syringe tip or transfer pipette tip above sample well and slowly inject the sample into sample well until you reach the fill line on cartridge. DO NOT OVER FILL!
9. Close the sample well with a snap.
10. Place the cartridge in the cartridge slot on the I-Stat.
11. The I-Stat will ask for your user ID twice. Enter your badge ID twice.
12. The I-Stat will ask for the patient ID twice. Enter in the patient number.
13. The test will take about three minutes.
14. When the test is complete press the PRT button to print the results.
15. Nursery staff will place results on a blue sheet of paper. Add sticker from chart and make sure you check arterial or venous blood. Take of copy of blue paper. One sheet is placed in patient's chart and other is sent to lab.
16. Manually enter (according to LabDAQ policy) into LabDAQ. Be sure to check and double check your manually entry.
17. I-STAT print out is attached to the LabDAQ requisition and sent to lab manager.

MAINTENANCE

MOUNTAIN VIEW HOSPITAL

	DEPARTMENT: LAB		CHAPTER: POINT OF CARE	
	POLICY: **I-STAT Policy**			
	Author: Amanda Tinsley	*Revised Date:* 01/15/2010	*Policy #:*	*Page 1 of 3*

POLICY

The I-STAT is a portable clinical analyzer that is intended for bed side testing. Mountain View Hospital uses this analyzer in our Nursery and our Redicare. The I-Stat is considered a waived test.

PROCEDURE

RUNNING CONTROLS PROCEDURE

Controls are to be run after calibration and with every lot change.

1. Take controls out of fridge and place on rocker. Let them come to room temperature.
2. Take one cartridge for every level of control out of fridge. Let them sit at room temperature for 20 minutes.
3. Open cartridges, making sure not to touch gold connectors on the top of the cartridge, and place cartridges on a dry, clean, flat, hard surface.
4. Take a syringe with attached needle and slowly aspirate the control into needle. Remove one mL of control. Expel all of the air bubbles out of syringe and remove needle from control bottle. Set control back on rocker.
5. Activate safety device and take needle off of syringe. Discard needle into sharps container.
6. Expel 1-2 drops into sharps container to ensure there is no air bubbles in syringe.
7. Place syringe tip above sample well and slowly inject the control into sample well until you reach the fill line on cartridge.
8. Close the sample well with a snap.
9. Place the cartridge in the cartridge slot on the I-Stat.
10. The I-Stat will ask for your user ID twice. Enter your badge ID twice.
11. The I-Stat will ask for the patient ID twice. Type in the control number.
12. The test will take about three minutes.
13. When the test is complete press the PRT button. This will print the result. Write the level of control and lot number on the print out.
14. Check the results against the reference ranges in the I-Stat Q.C. log. If OK place print out in log book.
15. Repeat steps 4-14 for the rest of the levels of controls.
16. On the boxes of cartridges with the same lot number; write "Q.C. Passed" and the date.

ELECTRONIC STIMULATOR PROCEDURE

Electronic Stimulator Control is ran daily.

4.15 Documentation and Reporting (Standard PC.03.05.15)

Restraint and seclusion must be documented fully in the patient's medical record (see graphic to the right).
Most facilities have specific documents:
- To be used when ordering restraint
- To fill out when monitoring restraint

4.16 Reporting (Standard PC.03.05.19)

Hospitals must report deaths associated with the use of restraint and seclusion.
Hospitals must report to CMS each death that occurs:
- While a patient is restrained or secluded
- Within 24 hours after the patient has been restrained or secluded
- Within one week after the restraint or seclusion was used, if it was likely to have contributed to the patient's deathThe hospital is required to report deaths to the CMS by telephone no later than the close of business on the day following the knowledge of the death. The date and time of the death must be documented in the medical record.

4.17 Training (Standard PC.03.05.17)

All clinical staff members must know their facility's policies for behavioral restraint and seclusion.
All staff members who are likely to be involved in the use of restraint or seclusion must be trained.
This training must occur:
- At orientation
- Before participating in the use of restraint or seclusion
- On a periodic basisTraining is especially important for staff members who have the authority to place patients in restraint or seclusion. See the text image at the right for specific training requirements.

4.18 Review

The patient must be released from seclusion.
The patient must be reevaluated for the continued need for seclusion.
The patient must be sedated if he is still unable to contain his threatening behavior.
The patient must be given the opportunity to choose whether or not to continue the seclusion.
Select the answer that best fits the question.

4.19 Review

Hospitals must report to CMS each death that occurs:
While a patient is restrained or secluded
Within 24 hours after the patient has been restrained or secluded
Within one week after the restraint or seclusion was used, if it was likely to have contributed to the patient's death
All of the above
Select the answer that best fits the question.

4.20 Summary

You have completed the lesson on the Joint Commission standards for restraint and seclusion.

Amendment for State survey
Mountain View Hospital

Completion Up Date & Clarification

TAGE	DESCRIPTION	DATE OF COMPLETION
A747 INFECTION CONTROL	1. The hospital's suites were toured on 3/08/2010 Rooms 2, 4, and 5 were noted to have many tears in the linoleum. 2. **Plan of Correction:** Floors will be mended and sealed in room 2 4 5	April 20, 2010
A207 RESTRAINTS	1. The hospital's failure to ensure that staff that provided restraint training was qualified to teach course. 2. **Plan of Correction:** A staff member was designated as Restraint Coordinator and sent to Boise to receive formal training on April 19 – 22. Upon return she will review entire restraint program and make recommendation. She will also increase training level by performing additional didactical training that has not be included in our current training program.	April 19, 2010 Restraint training reviewed by Restraint Coordinator April 23, 2010

PLAN OF CORRECTION AMENDMENT 4/16/2010
Mountain View Hospital

TAG NUMBER	Description of how the actions will improve the processes that led to the deficiency cited	Responsible Personnel
equipment maintenance	involved the central lab manager to monitor the RediCare lab equipment. Redi Care lab personnel will also be attending lab in-services to maintain ongoing training. 2. Lab will also monitor Redi Care's compliance with expiration of equipment. 3. Redi-Care will designate a person to check expiration date once a month on all lab products.	
A747 Infection Control	1. **A747** The process failure was the lack of continuing education regarding infection control with hand washing, environmental assessments and reporting findings of infection control issues. This process improvement involved the entire hospital with hand washing awareness signage and mandatory training. Other process improvements were the monitoring of suction devices, multi use vials and Operating room floors. All process improvements will be monitored by the Infection Control committee along with the QA committee.	Infection Control Coordinator/Safety Officer and Education coordinator

PLAN OF CORRECTION AMENDMENT 4/16/2010
Mountain View Hospital

TAG NUMBER	Description of how the actions will Improve the processes that led to the deficiency cited	Responsible Personnel
records	3. **A952** H&P revision will enable patient to receive an assessment prior to every procedure. This change in process will improve patient safety by documenting any changes since the H&P was performed.	
A 490 Pharmaceutical Services	Following process improvement in regarding pharmaceutical service: 1. **A491** Medication process of administration, when used in an Off-Label use, will be reviewed and approved by the P&T committee. This process change will ensure safe delivery of medication to all MVH patients. Medication will be audited by the pharmacy department for off label use. P&T will also review and make recommendation regarding medication sampling management. This process improvement will designate a process for sampling accountability. 2. **A500** Medication will be reviewed by either the pharmacist or charge nurse (after hours) prior to use. This process will always be reviewed by the pharmacist when medications are used for chemical restraint. This process improvement will allow the RN to have a resource and a double check of the medication prior to administration. 3. **A502 & A503** A new device was implemented that allows cabinets to automatically lock when closed. This process improvement will assist the nurse in maintaining a secure environment for medication while being available for administration of medication. This process improvement involved every provider. We have established a process where you own your medication until delivered, administered or stored properly.	Pharmacy Manager
A490 continues	4. **A505** All medication will be monitored for expiration date by the pharmacy department. This process failure was the result of a department monitoring their own medications. The improvement is to have one department check all medication for expiration date and proper management.	Pharmacy Manager
A536 Safety for patients and personnel "Radiation Exposure"	1. **A536** The radiology department was not properly implementing shield use for patient and staff members. This process improvement will reduce staff and patient exposure by properly training staff and with ongoing monitoring of the radiology department. The Radiology department has also purchased additional shields in order to have more available for staff and patient use.	Radiology Manager
A724 Facilities supplies	1. **A724** Staff education on the need for quality assurance with lab testing equipment. This process improvement	Lab Manager

PLAN OF CORRECTION AMENDMENT 4/16/2010
Mountain View Hospital

TAG NUMBER	Description of how the actions will improve the processes that led to the deficiency cited	Responsible Personnel
A043 Governing body	The governing body receives reports regarding the hospital improvement processes. This will enable the body to give direction and input with the plan of correction.	Compliance Officer
A115, A131 Patient rights	This process change will improve the patient awareness of the individuals that are providing care and services to the patient. Name all individuals on informed consent.	Compliance Officer
A144 Patient rights care in safe settings	Environmental monitoring by Pharmacy, Operative Nurses, Engineering, Housekeeping, Restraint Coordinator and the Compliance department along with staff education regarding the potential harmful exposure of patients. This correction will develop a team prevention process.	Safety Officer, Pharmacy Manager, Compliance Officer
A164 Patient rights restraint or seclusion	This process improvement will enable MVH to implement an approved CMS restraint process that will allow staff member to receive the appropriate training and a formally trained Restraint Coordinator to oversee the program.	Restraint Coordinator
A166	Staff education on the appropriate documentation of updating the plan of care as it relates to restraints.	Restraint Coordinator
A167	Staff education on how to properly apply restraints. This will be done on a didactical training program.	Restraint Coordinator
A168, A169	Training for staff to understand the physician order's for restraints. This process will improve staff education and confidence regarding patient restraint issues related to physician ordering process. Process is to empower the RN to know what is and what is not an acceptable order for restraints.	Restraint Coordinator
A178	This process will ensure restraint implementation is performed correctly by providing a face to face evaluation.	Restraint Coordinator
A196, A207	Our Restraint Coordinator with formal training will have the appropriate and required training to instruct staff members as to how the restraints are to be applied and what type we should use. Along with education on alternatives to restraints, this will provide a safe application of restraints to our patients.	Restraint Coordinator
A267 Quality Indicators	1. MVH restraint use is minimal. This allows the Safety committee to review all restraint use. The Restraint Coordinator will present each case when a restraint has been used for the committee to review and make recommendations for improvement. Having an Occurrence report generated every time a restraint is used will initiate the process.	Compliance Officer
A267 Quality Indicators A438 Form and retention of	2. Medical records are reviewed both opened and closed. This process change will allow for author education on deficiencies cited and other areas of medical record documentation. All chart errors will be reviewed by both individuals and the department with errors in charting. This data will be presented at QA committee.	Peri-op nursing manager.

PLAN OF CORRECTION AMENDMENT 4/16/2010
Mountain View Hospital

TAG NUMBER	Description of how the actions will improve the processes that led to the deficiency cited	Responsible Personnel
equipment maintenance	involved the central lab manager to monitor the RediCare lab equipment. Redi Care lab personnel will also be attending lab in-services to maintain ongoing training. 2. Lab will also monitor Redi Care's compliance with expiration of equipment. 3. Redi-Care will designate a person to check expiration date once a month on all lab products.	
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TAB 1

SEC 1

CONSENT FOR ANESTHESIA SERVICES

Mountain View Hospital, Idaho Falls, ID

I ***The Paitent*** acknowledge that my doctor has explained to me that I will have an operation, diagnostic or treatment procedure. My doctor has explained the risks of the procedure, advised me of alternative treatments and told me about he expected outcome and what could happen if my condition remains untreated. I also understand that ANESTHESIA SERVICES are needed so that my doctor can perform the operation or procedure. I understand that my operation, diagnostic or treatment procedure involves some risks and no guarantees or promises can be made concerning the results of my procedure, treatment or anesthesia. Although rare, unexpected severe complications with this procedure can occur and include the remote possibility of infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death. I understand that these risks apply to all forms of anesthesia and that additional or specific risks have been identified below as they may apply to a specific type of anesthesia. I understand that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor is to do, his or her preference, as well as my own desire. I understand that sometimes an anesthesia technique which involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia.

☐ General Anesthesia	Expected Result	Total unconscious state, possible placement of tube into windpipe/Trachea
	Technique	Drug injected into the bloodstream, breathed into lungs, or by other routes
	Risk	Mouth or throat pain, hoarseness, injury to mouth or teeth awareness under anesthesia. Injury to blood vessels, aspiration, pneumonia, or pulmonary edema, or visual impairment.
☐ Spinal or Epidural Analgesia/Anesthesia ☐ With sedation ☐ Without sedation	Expected Result	Temporary decreased or loss of feeling and /or movement to lower part of body
	Technique	Drug injected through a needle/catheter placed either directly into the spinal canal or immediately outside the spinal canal.
	Risk	Headache, backache, buzzing in the ears, convulsions, infection, persistent weakness, numbness, residual pain, injury to blood vessels.
☐ Major/Minor nerve block ☐ With sedation ☐ Without sedation	Expected Result	Temporary loss of feeling and/or movement of a limb
	Technique	Drug injected near nerves providing loss of sensation to the area of the operation.
	Risk	Infection, convulsions, weakness, persistent numbness, residual pain, injury to blood vessels.
☐ Intravenous Regional Anesthesia ☐ With sedation ☐ Without sedation	Expected Result	Temporary loss of feeling and /or movement of limb
	Technique	Drug injected into veins of arm or leg while using a tourniquet
	Risk	Infection, convulsions, persistent numbness, residual pain, injury to blood vessels
☐ Monitored Anesthesia care (with sedation)	Expected Result	Reduced anxiety and pain, partial or total amnesia
	Technique	Drug injected into the bloodstream, breathed into the lings, or by other routes producing a semi-comatose state.
	Risk	An unconscious state, depressed breathing, injury to the blood vessels.
☐ Monitored Anesthesia care (without sedation)	Expected Result	Measurement of vital signs, availability of anesthesia provider for further intervention.
	Technique	None
	Risk	Increased awareness, anxiety and/or discomfort

I hereby consent to the indicated anesthesia service and authorize _____ MD/CRNA to provide my anesthesia who may be a member of **Eagle Rock Anesthesia Group**. Your anesthesia will be administered by an Anesthesiologist and/or Certified Registered Nurse Anesthetist (CRNA) credentialed to provide anesthesia services at MVH. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by them. I expressly desire the following considerations be observed (or write none"):

_____

I certify that I have read this form or had it read to me, that I understand the risks, alternatives and expected results of the anesthesia service and that I had ample time to ask questions and to consider my decision.

Patient's Signature:_____

Date:_____ Time:_____

Substitute's Signature:_____

Relationship to Patient:_____

Witness:_____

Patient sticker

TAB 1

SEC 2

M ntain View Hospital
232_ Coronado street
Idaho Falls, ID

OPEN CHART REVIEW BY PACU AND POST SURGICAL

PATIENT NAME	CONSENT DEFICIENCY CIRCLE MISSING APPLICABLE	PROVIDER	DATE	AUDITOR
PATIENT STICKER	DATE PROVIDER'S NAME TIME PATIENT SIGNATURE ASSISTANT		/ /2010	
PATIENT STICKER	DATE PROVIDER'S NAME TIME PATIENT SIGNATURE ASSISTANT		/ /2010	
PATIENT STICKER	DATE PROVIDER'S NAME TIME PATIENT SIGNATURE ASSISTANT		/ /2010	
PATIENT STICKER	DATE PROVIDER'S NAME TIME PATIENT SIGNATURE ASSISTANT		/ /2010	
PATIENT STICKER	DATE PROVIDER'S NAME TIME PATIENT SIGNATURE ASSISTANT		/ /2010	
PATIENT STICKER	DATE PROVIDER'S NAME TIME PATIENT SIGNATURE ASSISTANT		/ /2010	

TAB 1

SEC 3

Re: State survey findings

Dear Anesthesia provider

During our state survey on March 6 – 11. Mountain View Hospital received a few citations regarding Anesthesia informed consent and medication management. The state findings were:

"The hospital's "Informed Consent" policy stated that informed consent process included identification of physician or other practitioners who had primary responsibility for the patient's care, as well as, the identity and professional status of the individual responsible for authorizing and performing the procedure or treatment. However, the hospital failed to obtain fully informed consents"

In-order for MVH to maintain its contract with CMS we must comply with CMS standards.

The state also cited us for the inappropriate storage of medication. It was discovered during their survey that several medication were left in an accessible area either on cart in hallway or cart was found unlocked. In-order for us to correct these action we will be monitoring all staff members for compliance. An Occurrence report will be generated when a medication if found to be in an unsecure area. We will respond to each of these occurrence reports. Please help us continue to improve our process. The state surveyors will be back this month to measure our compliance. If we have not complied with these standards than we will no-longer be able to participate with CMS and several other insurance companies, this will have a great effect on how we conduct our business; this will have a great effect on how we conduct our business.

We appreciate you assistance and efforts to correct these actions.

Thank You

Ned Hillyard
Compliance Officer

	DEPARTMENT: HOSPITAL-WIDE		*CHAPTER:*	
	POLICY: **INFORMED CONSENT**			
	Approved:Board Managers *Date: 10/2002*	*Revised Date:* 1/2010 BOM approved 2/210	*Policy #:* 1311	*Page 1 of 9*

POLICY

1. Mountain View Hospital (MVH) believes and supports the idea that the patient has the right to be involved in all aspects of their care, to have their treatment or services requested respected and supported so long as that care is within the hospital's capacity, its stated mission and philosophy and relevant laws and regulations.

2. The patient, and when appropriate the family, is given a clear, concise explanation of the patient's condition and any proposed treatment(s) or procedure(s), the potential benefit(s) and drawback(s) of the proposed treatment(s) or procedure(s), problems related to recuperation, and the likelihood of success. Information is also provided regarding the possible results of non-treatment and any significant alternative treatment(s) or procedure(s).

3. All patients asked to participate in a research project are given information to obtain an informed consent. Patients, and when applicable their families, are involved in resolving dilemmas about care decisions. The patient's right to privacy, confidentiality and safety are always respected.

4. Lack of informed consent can result in a battery charge. Complex procedures require informed consents: blood transfusion is defined as a complex procedure.

5. It is the treating physician's responsibility to obtain informed consent. The duty to provide this information and obtain informed consent is the exclusive duty of the treating physician. How the physician obtains informed consent is within the discretion of the physician.

6. The Idaho HealthCare Rules and Minimum Standards for Hospitals is the official resource for all issues relating to consent, including informed consent.

PROCEDURE

1. Information included in the informed consent process should include the identity of the physician or other practitioner, who has primary responsibility for the patient's care, and the identity and professional status of individuals responsible for authorizing and performing procedures or treatments.

2. Also included should be the existence of any professional relationship among individuals who are treating the patient, as well as the relationship to any other health care or educational institutions involved in the patient's care.

3. Mechanisms developed by the Medical Staff in collaboration with others guide and support the following:

   A. Documentation for the disclosure process, i.e., discussions with the patient relative to the specific benefits and drawbacks of the treatment or procedure, including impact on routines of daily living and alternate therapies when available.

   B. Access to translation services when appropriate.

   C. Access to appropriate audio visual aids.

   D. A method to assess and document evidence of patient understanding.

   E. Documentation of patient consent for procedures when required.

   F. Potential discomfort and risks.

   G. Alternative services that may also prove advantageous.

4. Patient medical records at MVH shall contain evidence of the patient's informed consent for any procedure or treatment that requires same, according to By-laws and/or the Medical Staff Rules and Regulations.

   A. Informed Consent process should include:

      1) Identity of the patient.

      2) The date the consent form is signed.

      3) Procedure or treatment to be rendered, in layman terminology when possible.

      4) The name(s) of the individual(s) who will perform or administer the treatment.

      5) Authorization for anesthesia, if indicated.

      6) An indication that alternative means of therapy and the possibility of risks, complications and benefits have been explained to the patient.

      7) Authorization for disposition of any tissue or body parts as indicated.

      8) The signature of the patient or other person empowered to give consent must be witnessed by a professional employee of MVH.

5. When Informed Consent is/is not needed:

   A. Informed Consent is necessary before performing any procedure or treatment other than simple or common procedures wherein the risk is low and is commonly understood. (See

attached list of procedures requiring informed consent.)

B. Informed consent is not required in a medical emergency situation when the patient is not able or competent to give consent and has not previously withheld consent for the planned procedure. Idaho law describes an emergency situation as requiring "immediate services for alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable medical conditions which, if not immediately diagnosed and treated, would lead to serious disability or death."

7. Physician's Role:

A. It is the treating physician's/provider's duty and responsibility to personally obtain informed consent; it may not be delegated to non-physicians/provider's.

B. For special procedures carried out in Radiology, the radiologist performing the procedure(s) shall be responsible for obtaining the patient's informed consent and documentation of such.

C. For radiotherapy procedures or treatments, the physician performing the procedure or treatment is responsible for obtaining informed consent.

D. The recommended process for obtaining informed consent is by direct discussion with the patient. This process may be facilitated by provision of printed material, use of video tapes or use of support information from a specially qualified designated person (but not as a substitute for the physician). The informed consent process must allow the patient an opportunity to ask questions about the information presented.

8. Who May Lawfully Give Informed Consent:

A. Adult patient, who is competent to understand;

B. Conservator of adult patient, when conservator papers specifically give authority to make healthcare decisions; otherwise, conservatee retains this right, if competent;

C. Consent by next of kin of an incompetent adult without conservator may be accepted under the following conditions:

1) Procedure is necessary and the patient is unlikely to regain competency soon.

2) Relative's competency or motives are not suspect.

3) Medical procedure requested has expected benefits and will not result in severe debilitation, such as loss of limb by amputation and/or does not involve a significant chance of a negative outcome, such as the risk of paresis.

D. Person designated by patient as "attorney in fact" under a valid Durable Power of Attorney

for Healthcare Decisions.

E. For an incompetent adult patient, a person designated by court order, under the Probate Code, not to included mental health treatment, use of experimental drugs or reproductive sterilization. *Idaho State code.*

F. Parent (either father or mother, natural or adoptive) of a minor patient.

G. Guardian of a minor patient:

1) When a minor in the custody of a legal guardian is given treatment, a certified copy of the official letters of guardianship will be obtained and placed in the patient's medical record prior to proceeding with treatment in a non-emergency.

H. For treatment of a minor, an adult person who has been authorized in writing by a parent or guardian of the patient, for consent to x-ray, anesthesia, medical or surgical diagnosis or treatment and hospital care, upon the advice of a licensed physician.

I. For a minor patient with no parent or guardian available, the court may summarily grant consent (under the Probate Code).

J. For direction in special circumstances involving minors who lack capacity to consent, such as divorced parents, adopted, born out of wedlock, in custody etc.

K. Minor patient (under 18 years) when any of the following apply:

1) Emancipated, any of these:

a. Married, present or past

b. On active duty with armed forces

c. By court declaration

2) Self-sufficient, all of these:

a. 16 years or older

b. Not living at parents' home

3) Unmarried, care related to pregnancy, includes pregnancy testing, birth control, abortion, excludes sterilization.

4) Care for sexual assault

5) 12 years or older, any of these:

a. Care for reportable or sexually transmitted disease.

b. Care and counseling for drug and alcohol abuse.

c. Psychiatric outpatient treatment or counseling when minor is mature enough to participate intelligently and is a danger to self or others, or is a victim of abuse.

d. Minor, 17 years of age or older, making donation of blood

9. Consent for Patients Without Surrogates:

A. When informed consent is needed in non-emergency situations and the patient is unable to provide consent and there are no known surrogate decision makers, the CHA Consent Manual Guidelines should be followed. In some circumstances the hospital attorney may need to be consulted for direction.

10. Use of Consent Form:

A. The employee having the patient sign the consent form must verify that informed consent has been obtained by the physician.

B. The consent form alone is not an "informed" consent.

C. If an interpreter is used during the discussion, the interpreter's name must be included on the consent form.

D. In the event that the person required to sign is physically unable, the patient's mark must be obtained. This is done by the facility representative writing the patient's name in full and then having the person place his "mark" (X) beneath it. Two witnesses must observe the process and sign the document as well.

11. Documentation by Physician:

A. The physician obtaining the informed consent shall make a note in the patient's medical record which summarizes the discussion with the patient regarding the intended treatment and the patient's responses, comprehension and agreement.

B. If an interpreter is used during the discussion, the interpreter's name should be indicated in the note.

12. Conditions of Refusal:

A. If a patient consents, but requests not to be informed of risks or to hear details of a procedure, the physician has no duty to inform the patient. Such consent is valid. The physician's note should include the patient's request.

B. If the patient refuses to consent to a treatment regime, such refusal should be documented in the patient's medical record.

13. Competency of Patients to Consent:

    A. A patient is presumed to be competent unless there is evidence to the contrary. Competency depends on the patient's ability to understand the nature and risks of the proposed treatment or procedure; that ability should not be impaired at the time of the consent discussion.

    B. Incompetency is not limited to legal declaration thereof.

    C. It is the physician's decision whether or not a patient is able to understand the informed consent and make a knowledgeable decision at the time it is discussed.

14. Duration of the Informed Consent and Consent Form:

    A. Consent can be considered effective until circumstances change which affect the nature of the planned procedure or until changes occur in the patient's condition that alter the risks or alternatives.

    B. Generally, consent is valid only during the hospitalization for which the procedure was planned.

    C. A patient can revoke consent at any time.

    D. A new consent must be obtained if a different procedural technique is to be used than was discussed with the patient and is written on the consent form.

    E. If there is a significant time delay (i.e., several days) between the original scheduled procedure and the actual performance of the procedure, it is advisable to verify that the patient is still in agreement with undergoing the procedure or test.

15. Telephone Consent

    A. Consent for medical or surgical treatment should be obtained by telephone only if the person(s) having legal capacity to consent for the patient is (are) not available.

    B. The physician should follow the standard protocol for obtaining consent for medical treatment.

    C. Once the physician states that he/she has obtained consent to treat the patient, hospital staff should verify that the patient's legal representative and physician have discussed the patient's condition and recommended treatment and the patient's representative has, in fact, given consent.

    D. In addition to verifying consent to treatment, hospital staff should also obtain the legal representative's written agreement to the "Conditions of Admission."

    E. The discussion between the patient's legal representative and the hospital staff should be witnessed by a hospital employee, and the exact time and nature of the consent should be

carefully documented. The patient's legal representative should be informed that another hospital employee will be listening to the discussion.

F. Both the hospital staff member (who obtains consent to the "Conditions of Admission" and verifies the consent for medical treatment) and the witness should sign and date this record and any forms that were involved. All such documents should be placed in and made a permanent part of the patient's medical record.

16. Hospital's Role in Informed Consent:

A. The hospital is obliged to verify that an informed consent has been obtained and that a signed consent form is in the patient's permanent medical record.

B. After the physician discusses the scheduled procedure with the patient and obtains informed consent, the hospital employee should ascertain if the patient does or does not understand the pertinent elements of the scheduled procedure. If the patient does not completely understand what he/she has consented to, the physician must be notified.

C. If a patient indicates to an employee that he/she has changed his or her mind about agreeing to a procedure, the employee must notify the treating physician.

17. Certain procedures and treatments have additional limitations and/or requirements. These include:

- Consent for use of organs, tissues, and fluids for research and commercial purposes
- Informed consent for use of physical restraints, psychotherapeutic drugs and the prolonged use of a device in skilled nursing facilities
- Consent for hysterectomy
- Consent for reuse of hemodialysis filters
- Consent for use of silicone implants and collagen injections
- Consent for antipsychotic medications
- Consent for convulsive therapy
- Consent to implantation of sperm, ova, or embryos
- Consent for blood transfusions
- Consent for sterilization
- Consent for abortion
- Consent for treatment of breast cancer and prostate cancer
- Consent for vaccines
- Consent for psychosurgery
- Consent to donation of sperm or ova
- Consent to Telemedicine

Note: For further information on these situations, *Idaho State code/ Informed Consent*

18. In the case of an emergency when treatment is immediately required and necessary to prevent deterioration or aggravation of the patient's condition, treatment may be given without the patient's consent. The law implies consent in the case of any emergency on the theory that if the patient were able, he/she would consent to the treatment. In the event of such an emergency the following

procedures will be used:

A. A physician must determine whether the treatment is immediately required and necessary to prevent deterioration or aggravation of the patient's condition, and the scope of the emergency, whether to treat the emergency only with temporary medical care in lieu of actual surgical procedures.

B. The physician may choose to obtain consultation from another physician to determine the necessity of treatment and scope of the emergency.

C. The possibility of waiting to obtain the consent from the patient or a legal representative of the patient will be weighed against the possibility that a delay for consent would result in deterioration or aggravation of the condition of the patient.

D. The physician must document on the patient's chart that the emergency exists, (i.e., "The immediate treatment of the patient is necessary because...")

1) The physician does not sign a consent form on behalf of the patient.

2) If a consultation from another physician was obtained, the consulting physician should also document this opinion in the patient's chart.

19. Informed Consent shall be obtained, but will not be limited to the following procedures:

- Angiograms
- Aortograms, arteriographies
- Arthrograms
- Hysterosalpingograms
- Myelograms
- Transhepatocholangiographies
- Renal cyst punctures
- Venograms
- Fistula/Sinus tract exams
- CAT scan that requires IV contrast
- Cholangiography
- Cyst puncture
- Radionuclide cysternogram
- Stent Placement
- Urography/Cystography
- Radiology exam requiring IV contrast, I., e. IVP
- Any other invasive procedure
- Colonoscopies
- Sigmoidoscopies
- Esophagoscopies, gastroscopies, duodenoscopies or combinations of these
- Spinal punctures Anesthetic blocks
- Bronchoscopies
- Biopsies
- Insertion of vascular catheters
- Insertion of temporary pacemakers, permanent pacemakers, electrode batteries
- Laryngoscopies
- Blood transfusion
- Any other test or procedure which may require

- MRI exams requiring IV contrast

the patient to be placed under conscious sedation.

Chief of Medical Staff:

_SIGNATURE ON FILE_____ _____
Barry Bennett MD Date

Chairperson of the Board of Managers

___SIGNATURE ON FILE_____ _____
Greg West MD (Vice Chairperson) Date


STERIS
FLUIDS ONLY
TEMPERATURE RANGE
BLANKETS ONLY

TAB 3

SEC 1

PLAN FOR CORRECTION FOR A144,A164, A166,A167,A168,A169, A178,A196, A207,A267

RESPONSE TO PATIENT RIGHTS 482.13 RESTRAINTS

Phase 1 policy revision
The policy will be revised to meet all COP 482.13.
The appointment of an Restraint Coordinator
Completion date: 4/1/2010

Have policy approved by BOM BB115 A043
RN supervisor Accept position of Restraint Coordinator and educator.
Completion date: 4/7/2010

Restraint policy will meet the following requirement see TAB 3 SEC 4
Provide safe Restraint practice with education and monitoring of patient. A team approach with implementation and review A144

Restraint Flow Sheet for RN documentation

Flow sheet was developed with required documentation

A178 Physician face to face documented

A178 BB283 Pharmacist review Chemical restraint orders

Required timed intervals for nursing to assessments

All Restraints will be entered into Restraint log.
Log will be forwarded to QA

Restraint formal education and staff members education

A207
Restraint Coordinator four day class found in Boise
Class is from April 19 – 22
Until course completion all staff will watch Restraint DVD
4/19/2010

A196
Restraint education for RN/LPN
- Health Stream online course which includes policy orientation
- Didactical training for restraint use

All other clinical assisting staff members will be trained
- Health Stream with policy orientation
- Code Green policy orientation
- Annual Code Green drills
- All drills will be reviewed by the safety committee

A164
Type of Restraint defined

A164
How to and alternatives Defined in policy

Staff education

A196
How to apply restraints

Didactical training provided by Restraint Coordinator Complete training 4/22/10

Temporary Didactical training will be provided by DVD Until 4/28/10

A168
Order requirements for restraints

Chemical restraint monitoring P&T committee approved the use of Haldol for IV use for the purpose of pt restraint 4/07/2010 Committee meeting min

A169
No PRN order for chemical and or any other Restraint orders

A267
Quality Assurance review of restraints

A267
A490
QA measures Pharmacy will note any time Haldol IV is used outside of Anesthesia QA will be notified and perform a chart review for restraint issues

Restraint use is rare at MVH. QA will audit all restraint use And safety committee will review Restraint Log

BB115
BB124
QA will include restraint report in Board of manager report

A166
Documentation for Plan of care up date

BB175
BB283
Plan of care are reviewed by the inter discipline team

Per policy and Health Stream staff member are educated on documentation requirement for plan of care

PLAN WILL BE FULL IMPLEMENTED BY 4/19/2010
EXCEPT FOR TRAINING OF RESTAINT COORDINATOR COMPLETION DATE: 4/22/2010

TAB 3

SEC 2

1ST TEST RN/LPN

2ND TEST RT, RAD, PT, CNA, HOUSEKEEPING ENGINEERING

1. Introduction

1.1 Introduction

Welcome to the introductory lesson on patient restraint and seclusion in the acute care setting. This lesson will provide the course rationale, goals, and outline.
As your partner, HealthStream strives to provide its customers with excellence in regulatory learning solutions. As new guidelines are continually issued by regulatory agencies, we work to update courses, as needed, in a timely manner. Since responsibility for complying with new guidelines remains with your organization, HealthStream encourages you to routinely check all relevant regulatory agencies directly for the latest updates for clinical/organizational guidelines.
If you have concerns about any aspect of the safety or quality of patient care in your organization, be aware that you may report these concerns directly to The Joint Commission.

1.2 Course Rationale

Sometimes restraining or secluding a patient can prevent injury or save lives. However, improper use of restraint can also cause injury or death. Therefore, restraint and seclusion should never be used as first choices. Instead, they should be used as last resorts, only when absolutely necessary.
This helps protect patient safety, rights, and dignity. It also helps your organization comply with regulatory standards.
In 2009, the Joint Commission updated their restraint and seclusion standards to more closely align with the CMS. There are now two sets of standards for restraint and seclusion.
Those that apply to:

- Hospitals that use Joint Commission accreditation for deemed status
- All other hospitalsThis course will discuss standards that must be followed by hospitals that ***use accreditation for deemed status.***

Please note: The use of restraint and seclusion must be done in accordance with hospital policy and law and regulation. Your hospital may differ. For example, some hospitals may not allow the involvement of clinical psychologists. Please consult your supervisor if you have questions.

1.3 Course Goals

After completing this course, you should be able to:

- Define restraint and seclusion
- List risks of restraint and seclusion
- Recognize best practices and regulatory standards for the use of restraint and seclusion

1.4 Course Outline

This introductory lesson provided the course rationale and goals.
Lesson 2 will present background information on restraint and seclusion.
Lesson 3 will describe the risks of restraint and seclusion.
Lesson 4 will give standards and clinical best practices for the use of restraint and seclusion.

2. Definitions and Background

2.1 Introduction & Objectives

Welcome to the lesson on background information.
After completing this lesson, you should be able to:
- Define restraint and seclusion
- Differentiate between physical and chemical restraint
- Distinguish between restraint for nonviolent patients and restraint for violent patients.

2.2 Restraint

Restraint is any method for limiting:
- Patient movement
- Patient activity
- A patient's normal ability to reach parts of

his or her own bodyRestraint may be:
- Physical
- ChemicalLet's take a closer look at each.

2.3 Restraint: Physical (1)

Examples of common **physical restraints** are:
- Belts
- Vests
- Ties
- Limb restraints (two-point, four-point)
- Therapeutic holds
- Special chairs
- Bedside rails

2.4 Restraint: Physical (2)

Keep in mind: A physical restraint could be *any* object or device.
If an object or device limits a patient in a physical way, then that object or device is a physical restraint **for that patient.**
Whether or not the device is meant to be a restraint does not matter.

2.5 Restraint: Chemical (1)

Chemical restraint means using drugs to help a patient control dangerous behavior.
Do not confuse chemical restraint with drug treatment. For example, using antidepressants to treat depression is NOT a form of chemical restraint.
Note: The Joint Commission specifically focuses on physical restraint in their standards. The recommendations given in later lessons also may apply to chemical restraint. However, you should consult facility policy and state regulations about the use of chemical restraint.

2.6 Restraint: Chemical (2)

Common chemical restraints fall into two major groups:

- Tranquilizers and anti-psychotic drugs
- BenzodiazepinesThe primary **tranquilizer** used as a chemical restraint is haloperidol (Haldol).

Benzodiazepines used to restrain patients include:

- Diazepam (Valium)
- Lorazepam (Ativan)
- Alprazolam (Xanax)

2.7 Seclusion

Seclusion means placing a patient alone in a room.
The patient is not allowed to leave the room.
In some facilities, special areas or rooms are designated to be used for seclusion.

2.8 Reasons for Restraint or Seclusion: Violent vs. Nonviolent

The decision to use restraint or seclusion is based on the patient's behavior. Each patient must be assessed to determine if restraint or seclusion is needed.
Restraint may be used for a patient who is:
Violent or self-destructive Violent or self-destructive
Patients in a hospital may become violent or self-destructive. Restraint is appropriate if the patient's behavior jeopardizes the immediate safety of:

- **The patient**
- **The medical staff**
- **Others in the area**

Nonviolent or non-destructive Nonviolent or non-destructive
In some situations, patients must be protected from unintentionally harming themselves. In this case, restraint may be appropriate to ensure the patient's physical safety. The use of restraint for nonviolent patients must be clinically justified.
Click on each category of restraint for additional information.

2.9 Exceptions

Keep in mind: Under the Joint Commission standards, 'restraint' and 'seclusion' do not mean:

- Restraint used for procedures, when restraint is a standard part of the procedure (for example, surgical positioning devices)
- Necessary support devices (for example, orthopedic braces)
- Necessary devices for medical protection (for example, protective helmets)
- The use of surgical dressings or bandages
- Methods that protect the patient from falling out of bed
- Methods that permit the patient to participate in activities without the risk of physical harm (does not include a physical escort)
- Physically holding a patient to allow routine physical examination or testing
- Placing a patient in an unlocked room or area, according to facility policy and procedure
- Restraint used by law enforcement on criminals

2.10 Review

True
False
Select the answer that best fits the question.

2.11 Review

2.12 Summary

You have completed the lesson on definitions and background.
Remember:

- **Restraint** is any physical or chemical method for limiting or controlling what a patient is able to do.
- A **physical restraint** is ***any*** object or device that limits a patient physically. **Chemical restraint** means giving a drug to help a patient control dangerous behavior.
- **Seclusion** means placing a patient alone in a room.
- Restraint may be used for a violent, self-destructive patient to protect the immediate safety of the patient, staff, or others.
- Restraint may also be used to ensure the safety of nonviolent patients.
- Seclusion may be used to control behavior to prevent a patient from doing physical harm.
- Joint Commission standards regulate the use of restraint and seclusion.

3. Risks of Restraint & Seclusion

3.1 Introduction

Welcome to the lesson on the risks of restraint and seclusion.
After completing this lesson, you should be able to:

- List examples of the proper use of restraint and seclusion
- List psychological and physical risks of restraint and seclusion
- Cite risk factors, immediate causes, and root causes of restraint-related deaths
- List the risks of chemical restraint

3.2 Restraint-Related Injury and Death

Restraint is sometimes necessary to support healing or prevent harm. Unfortunately, restraint can also be harmful for a patient.
According to The Joint Commission, restraint-related deaths and injuries accounted for 3.4% of all sentinel events as of December 31, 2008.
This lesson discusses these sentinel events and other risks of restraint and seclusion.
This will help you understand the reasons for the best practices and regulatory standards described in lesson 4.

3.3 Proper Use of Restraint & Seclusion

Restraint or seclusion is sometimes necessary.
Consider these cases:

- A patient may need to be restrained to keep necessary medical devices in place. For example, a patient may need to be restrained if he or she repeatedly removes a necessary IV line.
- A patient may need to be restrained to make it possible to work on or with the patient. This may be the case if the patient resists needed care because it is uncomfortable or unpleasant. For example, a patient may need to be restrained to make it possible to insert a nasogastric tube.
- A patient may need to be restrained or secluded to prevent the patient from doing harm during an episode of violence or acute psychosis.
- A suicidal or homicidal patient may need to be restrained or secluded to prevent the patient from leaving the facility.

3.4 Risks of Restraint & Seclusion: Overview

In short, restraint and seclusion are sometimes necessary.
At the same time, restraint and seclusion always have some risks.
These risks include:

- Psychological harm to the patient (restraint or seclusion can be very traumatic, especially for certain patients)
- Loss of patient dignity
- Violation of patient rightsIf restraint is used incorrectly, the patient also may suffer serious physical injury. Even death is possible.

3.5 The Joint Commission Study: Restraint-Related Deaths

In a Joint Commission study of 20 deaths due to the use of physical restraint:

- Twelve occurred in psychiatric hospitals
- Six occurred in general hospitals
- Two occurred in long-term care facilitiesIn 40% of the cases, the direct cause of death was suffocation.

Patients suffocated because of factors such as:

- Too much weight on their backs, when they were restrained in the prone position
- Towels or sheets placed over their heads, to protect staff members from bites or spitting
- Pressure on the airway when the patient's arm was pulled across his or her neck

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3.6 The Joint Commission Study: Causes of Death

The remaining 60% of deaths in the Joint Commission study happened because of:

- Strangulation
- Cardiac arrest
- FireAll of the patients who died of strangulation were geriatric patients in vest restraints. Fifty percent of these patients died after slipping between unprotected split bedrails.

All of the patients who died as a result of fire were male. These patients were trying to smoke or burn off their restraints with a cigarette lighter.

3.7 The Joint Commission Study: Risk Factors

The Joint Commission identified the following risk factors for death from physical restraint:

- Restraining patients who smoke
- Restraining patients with physical deformities that make it impossible to use the restraining device properly
- Supine restraint, which increases the risk of taking fluid into the lungs
- Prone restraint, which increases the risk of suffocation
- Failure of staff to monitor restrained patients continuously

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3.8 The Joint Commission Study: Root Causes

3.9 Chemical-Restraint Risks

Chemical restraint can help some patients control their dangerous behavior. However, chemical restraint has medical risks. These include:

- Allergic reactions to the drug
- Weakened breathing
- Loss of gag reflex, which increases the risk of choking and taking fluid into the lungs
- Worsening of glaucoma
- Lowered blood pressure
- Effects on the heart
- Harm to the fetus (for pregnant women)Use of chemical restraint also makes it difficult to check a patient's mental status.

Finally, some patients have unusual reactions to drugs. In these patients, chemical restraint can make the problem worse. For example, Valium can increase the patient's agitation, instead of decreasing it.

3.10 Reducing Restraint and Seclusion

All facilities should try to reduce their use of restraint. Some facilities may be able to stop using restraint entirely.

Potential strategies for reducing the use of restraint include:

Early intervention strategies
Early intervention strategies
These strategies focus on taking action early to help reduce the need for restraint later. For example, measures should be in place to prevent crisis situations that may lead to the need for patient restraint or seclusion.

Alternatives to restraint
Alternatives to restraint
Alternative strategies focus on helping the patient heal without using restraint.

Assessing any patient who may be at risk for the use of restraints or seclusion at intake or admission is helpful. Find out ways to help a patient control dangerous behavior. Ask the patient what helps when he or she is upset. For example, a patient might find it soothing to:

- Write in a journal
- Talk to staff one-on-one
- Take a warm shower

Click on each item to reveal more information.

3.11 Using Restraint and Seclusion

When restraint is absolutely necessary, it should be used according to:
- Clinical best practice
- Law
- Regulatory and accreditation standards
- Hospital policy and procedureIn the next lesson, we will talk about the Joint Commission standards for restraint and seclusion.

3.12 Review

3.13 Summary

You have completed the lesson on risks of restraint and seclusion.
Remember:
- In some cases, restraint may be medically necessary.
- In other cases, restraint or seclusion may be necessary to control dangerous patient behavior.
- Risks of restraint and seclusion include psychological harm to the patient, loss of patient dignity, violation of patient rights, physical injury, and death.
- Root causes of death due to physical restraint have to do with: patient assessment, care planning, patient observation, staff, and equipment.
- Chemical restraint can cause medical problems.

4. Joint Commission Standards

4.1 Introduction & Objectives

Welcome to the lesson on Joint Commission Standards for Restraint and Seclusion.
After completing this lesson, you should be able to:

- Identify policies and practices that can help reduce the use of restraint and seclusion
- List the requirements that staff must meet to use restraint and seclusion safely and effectively
- Recognize the role of healthcare personnel when it comes to the use of restraint and seclusion
- Identify the steps in the restraint and seclusion process

4.2 Joint Commission Standards

The Joint Commission previously had two sets of standards. One set applied to the use of restraint and/or seclusion for medical or surgical reasons. The other applied to behavioral restraint and seclusion.
These two sets of standards have been combined to meet CMS requirements. Hospitals that use accreditation for deemed status must comply with Standards PC.03.05.01 to PC.03.05.19.
Throughout this lesson, specific Joint Commission standards will be given, for your reference.

4.3 When Restraint and Seclusion are Appropriate (Standard PC.03.05.01)

As we mentioned in the last lesson, the use of restraint or seclusion should be avoided whenever possible. However, this is not always possible.
Restraint only should be used when:
Less restrictive interventions are ineffective
Less restrictive interventions are ineffective
Restraint and seclusion should only be used if less restrictive measures are not effective.
Clinically justified
Clinically justified
Facilities must make certain that restraint is used only for proper clinical reasons. This means that restraint should be used only to treat certain symptoms or promote certain types of healing in a patient.

Examples of cases where restraint is needed to prevent patient injury include:

- When a patient is being treated for a condition such as post-traumatic brain injury
- When a patient is undergoing a procedure such as intubation

Warranted by patient behavior
Warranted by patient behavior
Hospitals may use restraint when warranted by patient behavior that threatens the physical safety of:

- The patient
- Staff
- Others present

It can be used to protect the *immediate* safety of these individuals.
Click on each acceptable use of restraint for additional information.

4.4 When Restraint and Seclusion are not Appropriate

Restraint and seclusion should **NEVER** be used to:
- Discipline a patient
- Make patient care tasks more convenient for staff
- Make a patient do something against his or her will
- Retaliate against a patient

4.5 Safely Using Restraint and Seclusion (Standard PC.03.05.01)

The rights and safety of a patient must be protected during restraint or seclusion.
To use restraint or seclusion safely, only trained staff members should apply and remove restraints. In addition, staff members should:
- Choose the LEAST limiting form of restraint that meets the patient's needs
- Discontinue restraint or seclusion as soon as possible, even if the order has not expired
- Protect the patient's safety, rights, dignity, and wellbeing throughout the use of restraintWhen assessing a patient who is at risk for the use of restraint or seclusion, collect information about:
- Conditions that could increase the risk of physical injury during restraint or seclusion
- Any history of abuse that might increase the risk of psychological harm during restraint or seclusion

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4.6 Safely Using Restraint and Seclusion (Standard PC.03.05.03)

Safe techniques for restraint and seclusion must be
implemented in accordance with:
- Hospital policy and procedure
- Written modification to the patient's plan of careExamples of safe restraint application are given in the
text image on the right.

4.7 Orders for the use of Restraint or Seclusion (Standard PC.03.05.05)

Restraint or seclusion is initiated based on an individual order.
A patient may be placed in restraint or seclusion only if it is ordered by a:
- Physician
- Licensed independent practitioner (LIP)
- Clinical psychologistThe physician, LIP, or clinical psychologist who orders restraint or seclusion must be primarily responsible for the patient's ongoing care.

If the attending physician, LIP, or clinical psychologist did not order the restraint or seclusion, he or she must be consulted as soon as possible.

4.8 Ordering Restraint or Seclusion: Violent or Self-Destructive Behavior (Standard PC.03.05.05)

Recall that restraint or seclusion can be ordered for patients who are violent or self-destructive.
These orders are time-limited (see graphic to the right). Remember, a patient can be released from the restraint or seclusion before the order expires.
Orders may not be written on a standing or 'as needed' (PRN) basis. They may be renewed according to the time limit for a maximum of 24 consecutive hours.
Every 24 hours, the physician, clinical psychologist, or LIP must see and evaluate the patient before writing a new order.

4.9 Ordering Restraint or Seclusion: Nonviolent Behavior (Standard PC.03.05.05)

Orders to protect the physical safety of a nonviolent or non-self destructive patient:
- May not be written on a standing or 'as needed' (PRN) basis
- Are renewed in accordance with hospital policy

4.10 Orders for Restraint: Your Facility (Standard PC.03.05.09)

All hospitals must have written policies and procedures that guide the use of restraint and seclusion. However, each facility may have slightly different guidelines for placing a patient in restraint. Physicians, clinical psychologists, and LIPs who can order restraint or seclusion must have a working knowledge of the hospital's policies.
Be certain that you know YOUR facility's policies on obtaining orders and applying restraint.

4.11 Patient Monitoring (Standard PC.03.05.07)

Qualified and trained staff must monitor the patient in restraints or seclusion.
Monitoring is necessary to be certain that:
- The patient's wellbeing is protected.
- The patient's rights, dignity, and safety are protected.
- The least limiting form of restraint is used at all times.
- The patient is released from restraint as soon as it is proper and safe.Restrained or secluded patients should be observed or examined according to facility policy and the specific patient.

4.12 Evaluation of the Violent Patient (Standard PC.03.05.11)

Violent, self-destructive patients who have been placed in restraints or seclusion must be evaluated and reevaluated in person.
The evaluation must focus on:
- The patient's immediate situation
- The patient's reaction to the intervention
- The patient's medical and behavior condition
- The need to continue or terminate the restraint or seclusion

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4.13 Evaluation of the Violent Patient: Time Frame (Standard PC.03.05.07)

The evaluation of violent, self-destructive patients who have been placed in restraints or seclusion must occur within **one hour**.
The evaluation may be done in-person by:
- A clinician responsible for the patient's care including:
- A physician
- A clinical psychologist
- A LIP
- A trained registered nurse (RN)
- A physician assistant (PA)If a RN or PA completes the assessment, the attending physician, clinical psychologist, or LIP must be consulted as soon as possible.

4.14 Simultaneous Restraint and Seclusion (Standard PC.03.05.13)

Patients who are simultaneously restrained and secluded must be continually monitored.
In this case, the monitoring must be done by trained staff either:
- In person
- Through the use of video *and* audio equipment that is in close proximity to the patient

4.15 Documentation and Reporting (Standard PC.03.05.15)

Restraint and seclusion must be documented fully in the patient's medical record (see graphic to the right).
Most facilities have specific documents:
- To be used when ordering restraint
- To fill out when monitoring restraint

4.16 Reporting (Standard PC.03.05.19)

Hospitals must report deaths associated with the use of restraint and seclusion.
Hospitals must report to CMS each death that occurs:
- While a patient is restrained or secluded
- Within 24 hours after the patient has been restrained or secluded
- Within one week after the restraint or seclusion was used, if it was likely to have contributed to the patient's deathThe hospital is required to report deaths to the CMS by telephone no later than the close of business on the day following the knowledge of the death. The date and time of the death must be documented in the medical record.

4.17 Training (Standard PC.03.05.17)

All clinical staff members must know their facility's policies for behavioral restraint and seclusion.
All staff members who are likely to be involved in the use of restraint or seclusion must be trained.
This training must occur:
- At orientation
- Before participating in the use of restraint or seclusion
- On a periodic basisTraining is especially important for staff members who have the authority to place patients in restraint or seclusion. See the text image at the right for specific training requirements.

4.18 Review

The patient must be released from seclusion.
The patient must be reevaluated for the continued need for seclusion.
The patient must be sedated if he is still unable to contain his threatening behavior.
The patient must be given the opportunity to choose whether or not to continue the seclusion.
Select the answer that best fits the question.

4.19 Review

Hospitals must report to CMS each death that occurs:
While a patient is restrained or secluded
Within 24 hours after the patient has been restrained or secluded
Within one week after the restraint or seclusion was used, if it was likely to have contributed to the patient's death
All of the above
Select the answer that best fits the question.

4.20 Summary

You have completed the lesson on the Joint Commission standards for restraint and seclusion.

Remember:

- Hospitals that use Joint Commission accreditation for deemed status must comply with standards PC.03.05.01 to PC.03.05.19.
- Restraint and seclusion are used only when clinically justified or warranted by patient behavior.
- The least restrictive method is used.
- Restraint and seclusion must be used safely.
- Restraint and seclusion are initiated based on an individual order. The order is time limited.
- The hospital must have written policies and procedures for restraint and seclusion.
- Restrained or secluded patients are evaluated and reevaluated.
- Restraint and seclusion are documented. Deaths must be reported to CMS.

Exam

Before taking this test, you are required to read Mountains View's Restraint Policy.

Examination Summary

- This examination contains **25** question(s).
- You must answer **80%** correctly or **20** out of **25** question(s) in order to pass this examination.
- Use Next/Previous rather than the scroll bar.
- Do **NOT** click the **X** on the upper right-hand corner of the window.
- Please answer all questions below, then click the SUBMIT button at the bottom of the page to have your examination scored.
- This assessment is not timed.

Question 1 of 25

According to Mountain View's restraint policy, what knot is used to tie a mechanical restraint?

Answers

○ square knot
○ granny knot
○ double-loop knot
○ easy release with one loop knot

Next

Question 2 of 25

Please select all answers that are correct. According to Mountain View Hospital's Restraint policy, ways to prevent. reduce or eliminate the use of restraints by:

Answers

☐ Preventing emergencies that have the potential to lead to the use of restraints
☐ Using the most restrictive method possible
☐ Limit the use of restraints to emergencies where there is a risk or the patient harming him/her or others
☐ Provide a physical assessment to identify medical problems that may be causing behavior changes in the patient such as elevated temperature, hypoxia, hypoglycemia, electrolyte imbalances, and drug interactions

Previous Next

Question 3 of 25

According to Mountain View's Restraint Policy, restraints are to be tied to the siderails or the mattress

Answers

○True
○False

Previous Next

Question 4 of 25

The time-limited order for behavioral health restraint expires. The patient is reevaluated by a healthcare professional (HCP). The HCP must:

Answers

○Be a licensed independent practitioner (LIP)
○Help the patient control his or her dangerous behavior
○Write a PRN ("as-needed") order for restraint if warranted by the reevaluation
○Decide whether or not continued monitoring of the restrained patient is necessary

Previous Next

Question 5 of 25

Mountain View's goal for the use of restraints is to:

Answers

○Keep patients where we want them
○Allow freedom of the patient no matter the cost
○Make sure that the paitent is safe but employee's safety doesn't matter
○To use the minimal amount of restraints to acheive the highest quality of safety for the patient and medical staff.

Previous Next

Question 6 of 25

Which of the following is the best definition of physical restraint?

Answers

○A device physically attached to a patient
○A device intended to limit a patient physically
○A device that has the effect of limiting a patient's movement
○A medication used to help a patient control dangerous behavior

Previous Next

Question 7 of 25

Seclusion may need to be used by employee's at Mountain View hospital

Answers

○True
○False

Previous Next

Question 8 of 25

If all of the following methods are EFFECTIVE for dealing with a patient's behavioral problems, which is the PREFERRED method?

Answers

- ○ Seclusion
- ○ Physical restraint
- ○ Chemical restraint
- ○ Nonphysical intervention

Previous Next

Question 9 of 25

Which risk is increased when patients are restrained in the supine position?

Answers

- ○ Cardiac arrest
- ○ Taking fluid into the lungs
- ○ Improper use of the restraining device
- ○ Suffocation due to pressure on the airway

Previous Next

Question 10 of 25

A recliner can be considered a retraint if a patient cannot get easlisy remove the restraint and get out of it on their own.

Answers

- ○ True
- ○ False

Previous Next

Question 11 of 25

The evaluation of violent, self-destructive patients who have been placed in restraints or seclusion must occur within:

Answers

- ○ 30 minutes
- ○ 60 minutes
- ○ 12 hours
- ○ 14 hours

Previous Next

Question 12 of 25

Which of the following is considered a restraint under Joint Commission standards?

Answers

- ○ Orthopedic brace
- ○ Two-point limb restraint
- ○ Surgical positioning device
- ○ Helmet used for medical protection

Previous Next

Question 13 of 25

According to Mountain View Hospital's Restraint Policy, chemical restraints may be administered by any licensed nurse.

Answers

- ○ True
- ○ False

Previous Next

Question 14 of 25

Tucking sheets tightly to prevent patient movement is not considered a restraint

Answers

- ○ True
- ○ False

Previous Next

Question 15 of 25

A medication is considered a chemical restraint if:

Answers

- ○ It is given to the patient to control the behavior or to constrict the patient's freedom of movement
- ○ It is given to a patient for psychosis
- ○ If the medication is given to the patient to help them sleep
- ○ If the medication is given to the patient for pain

Previous Next

Question 16 of 25

According to Mountain View's restraint policy, if a nurse is concerned that their patient may get out of bed and fall, it is alright to put all 4 bedrails up and it will not be considered a restraint.

Answers

○True
○False

Previous Next

Question 17 of 25

Individual orders for restraint may be renewed for a maximum of 24 consecutive hours.

Answers

○True
○False

Previous Next

Question 18 of 25

According to Mountain View's restraint policy, if needed, a restraint needs to be ordered every:

Answers

○8 hours
○every 12 hours
○every 24 hours
○every 48 hours

Previous Next

Question 19 of 25

Please select all of the correct answers. Physical restraints may be contraindicated:

Answers

☐In patients with a history of sexual abuse
☐When the physical restraint makes the patient more agitated
☐When the patient is actively hallucinating or delusional
☐When the patient is under 20 years of age

Previous Next

Question 20 of 25

Which of the following is a best practice to help protect the safety and rights of a patient who must be restrained?

Answers

○Restrain patients in bed with unprotected split bedside rails.
○Always choose the least limiting form of restraint that meets the patient's needs.
○The head should be prevented from rotating when a patient is restrained in the supine position.
○Restrain patients with behavioral problems at the very first indication that they may

lose control.

Previous Next

Question 21 of 25

I have read Mountain View's Restraint policy and agree to follow the standards and procedures indicated in that policy

Answers

- ○ Yes
- ○ No

Previous Next

Question 22 of 25

According to Mountain View's Restraint Policy, psychosocial support must be given to patient's in restraints:

Answers

- ○ Every 2 hours
- ○ Every 2 hours, and as needed
- ○ As needed
- ○ Every one hour and as needed

Previous Next

Question 23 of 25

According to Mountain View's policy, the patient's physician or LIP must perform a face to face evaluation within 30-60 minutes of the placement of restraints

Answers

- ○ True
- ○ False

Previous Next

Question 24 of 25

According to Mountain View's Restraint policy, the nurse must check the sedation level on a patient using chemical restraints:

Answers

- ○ Every one hour and every time a dose of medication is given
- ○ Every 2 hours and everytime a dose of medication is given
- ○ Every 30 minutes and everytime a dose of medication is given
- ○ Everytime a dose of medication is given

Previous Next

Question 25 of 25

According to Mountain View's Restraint policy, what mininum of staff members are needed whenever a restraint is released?

Answers

- ○ 1
- ○ 2
- ○ 3
- ○ 4

Previous

Close Pause Submit

Build 10.02.18.106.7

O:HLCWEB3 A:HLCWEB3 C:CONTENT7

Pre-Assessment

You must read Mountain View's Restraint Policy before taking this test

Examination Summary

- This examination contains **1** question(s).
- You must answer **100%** correctly or **1** out of **1** question(s) in order to pass this examination.
- Use Next/Previous rather than the scroll bar.
- Do **NOT** click the **X** on the upper right-hand corner of the window.
- Please answer all questions below, then click the SUBMIT button at the bottom of the page to have your examination scored.
- This assessment is not timed.

Question 1 of 1

I have read Mountain View's Restraint policy and agree to abide by it

Answers

◯ Yes
◯ No

Close Pause Submit

Build 10.02.18.106.7

O:HLCWEB3 A:HLCWEB3 C:CONTENT7

Exam

Examination Summary

- This examination contains **10** question(s).
- You must answer **80%** correctly or **8** out of **10** question(s) in order to pass this examination.
- Use Next/Previous rather than the scroll bar.
- Do **NOT** click the **X** on the upper right-hand corner of the window.
- Please answer all questions below, then click the SUBMIT button at the bottom of the page to have your examination scored.
- This assessment is not timed.

Question 1 of 10

Individual orders for restraint may be renewed for a maximum of 24 consecutive hours.

Answers

- ○ True
- ○ False

Next

Question 2 of 10

Which risk is increased when patients are restrained in the supine position?

Answers

- ○ Cardiac arrest
- ○ Taking fluid into the lungs
- ○ Improper use of the restraining device
- ○ Suffocation due to pressure on the airway

Previous Next

Question 3 of 10

The time-limited order for behavioral health restraint expires. The patient is reevaluated by a healthcare professional (HCP). The HCP must:

Answers

- ○ Be a licensed independent practitioner (LIP)
- ○ Help the patient control his or her dangerous behavior
- ○ Write a PRN ("as-needed") order for restraint if warranted by the reevaluation
- ○ Decide whether or not continued monitoring of the restrained patient is necessary

Previous Next

Question 4 of 10

When is restraint appropriate?

Answers

- ○ To help treat medical symptoms
- ○ To help discipline a problem patient
- ○ To help healthcare staff do their job more easily and conveniently
- ○ To help a patient's family members feel better about the patient's safety

Previous Next

Question 5 of 10

For adults, what is the maximum time limit for a single order for behavioral health restraint?

Answers

- ○ 24 hours
- ○ 48 hours
- ○ One hour
- ○ Four hours

Previous Next

Question 6 of 10

If all of the following methods are EFFECTIVE for dealing with a patient's behavioral problems, which is the PREFERRED method?

Answers

- ○ Seclusion
- ○ Physical restraint
- ○ Chemical restraint
- ○ Nonphysical intervention

Previous Next

Question 7 of 10

Which of the following is considered a restraint under Joint Commission standards?

Answers

- ○ Orthopedic brace
- ○ Two-point limb restraint
- ○ Surgical positioning device
- ○ Helmet used for medical protection

Previous Next

Question 8 of 10

Which of the following is a best practice to help protect the safety and rights of a patient

who must be restrained?

Answers

- ○ Restrain patients in bed with unprotected split bedside rails.
- ○ Always choose the least limiting form of restraint that meets the patient's needs.
- ○ The head should be prevented from rotating when a patient is restrained in the supine position.
- ○ Restrain patients with behavioral problems at the very first indication that they may lose control.

Previous Next

Question 9 of 10

Which of the following is the best definition of physical restraint?

Answers

- ○ A device physically attached to a patient
- ○ A device intended to limit a patient physically
- ○ A device that has the effect of limiting a patient's movement
- ○ A medication used to help a patient control dangerous behavior

Previous Next

Question 10 of 10

The evaluation of violent, self-destructive patients who have been placed in restraints or seclusion must occur within:

Answers

- ○ 30 minutes
- ○ 60 minutes
- ○ 12 hours
- ○ 14 hours

Previous

Close Pause Submit

Build 10.02.18.106.7

O:HLCWEB3 A:HLCWEB3 C:CONTENT7

SKILL VALIDATION TOOL

Restraints RN/LPN/RT Employees

Employee's Name:_____ Site:_____

OBJECTIVE: Employee will demonstrate the proper use of restraints

		SUCESSFULLY MET? YES	*Optional Date/Initials
1.	Correctly demonstrates tying and releasing of the easy release knot	_____	_____
2.	Demonstrates correct placement of arm splints to allow line protection (does not tie on siderails or the mattress)	_____	_____
3.	Demonstrates correct placement of mitts to allow fingers to move freely	_____	_____
4.	Demonstrates correct placement of vest restraint or lap belt allowing for as much movement of the patient as possible/		
5.	Verbally expresses 3 methods of de-escalation	_____	_____
5.	Demonstrates the ability to find and use the correct documentation tools needed if using restraints (i.e. document form, policy, physician orders)	_____	_____
6.	Demonstrates knowledge of the proper code to call if threatened with violence	_____	_____
7.	Demonstrates and/or verbalizes how to modify a plan of care for a restrained patient	_____	_____
8.	Completed viewing Providing Evidence/Restraints, Seclusion DVDs	_____	_____

COMMENTS:_____

_____

*Validator should date and initial steps completed if not a full return demonstration.

VALIDATOR:_____ DATE OF COMPLETION:_____

SKILL VALIDATION TOOL

Restraints (Housekeeping, Maintenance, Radiology. Physical Therapy, CNAs, Ward Clerks, Medical Aids, etc.)

Employee's Name:_____ Site:_____

OBJECTIVE: Employee will prove competency in their role regarding the Patient use of restraints and avoiding workplace violence

		SUCESSFULLY MET? YES	*Optional Date/Initials
1.	Correctly demonstrates tying and releasing of the easy release knot	_____	_____
2.	Demonstrates and/or verbalizes their role in a Code Green		
5.	Verbally expresses 3 methods for de-escalation	_____	_____
3.	Demonstrates the ability to find and use the correct documentation tools needed for use of restraints (i.e. document form, policy, physician orders)	_____	_____
4.	Completed viewing Providing Evidence/Restraints, Seclusion DVDs	_____	_____

COMMENTS:_____

_____

*Validator should date and initial steps completed if not a full return demonstration.

VALIDATOR:_____ DATE OF COMPLETION:_____

ALL EMPLOYEE TRAINING

Pre-Assessment

You must read Mountain View Hospital's "Restraints" and "Code Green" policies before taking this course. To access these, go to the Intranet and scroll over to the far left. Click on "New policy software". Type in "1010" by policy number or "restraint" by short description for the Restraint Policy. Hit "search". Type in "1012" by policy number or "Code Green" by short description.

Examination Summary

- This examination contains **2** question(s).
- You must answer **100%** correctly or **2** out of **2** question(s) in order to pass this examination.
- Use Next/Previous rather than the scroll bar.
- Do **NOT** click the **X** on the upper right-hand corner of the window.
- Please answer all questions below, then click the SUBMIT button at the bottom of the page to have your examination scored.
- This assessment is not timed.

Question 1 of 2

I have read and agree to comply to Mountain View's "Code Green" policy.

Answers

◯ Yes
◯ No

Next

Question 2 of 2

I have read and agree to comply to Mountain View Hospital's Restraint Policy

Answers

◯ Yes
◯ No

Previous

Close Pause Submit

Build 10.02.18.106.7

O:HLCWEB3 A:HLCWEB3 C:UNKNOWN

1. Introduction

1.1 Introduction

Welcome to the introductory lesson on workplace violence.
As your partner, HealthStream strives to provide its customers with excellence in regulatory learning solutions. As new guidelines are continually issued by regulatory agencies, we work to update courses, as needed, in a timely manner. Since responsibility for complying with new guidelines remains with your organization, HealthStream encourages you to routinely check all relevant regulatory agencies directly for the latest updates for clinical/organizational guidelines.
If you have concerns about any aspect of the safety or quality of patient care in your organization, be aware that you may report these concerns directly to The Joint Commission.

1.2 Course Rationale

Violence includes many behaviors. These behaviors range from rude language to murder. When violence happens to a person at work, that violence is considered to be workplace violence.
Workplace violence is a very real threat in the healthcare setting. Healthcare workers deal with patients and family members who often feel frustrated, vulnerable, and out of control. These people can become violent.
This course will teach you how to prevent and handle workplace violence.
You will learn:

- How, where, when, and why violence occurs in the healthcare setting
- The key parts of a Violence Prevention Program
- How to be safe around violent or potentially violent individuals

1.3 Course Goals

After completing this course, you should be able to:

- Recognize risk factors for violence in the healthcare setting
- List the parts of a Workplace Violence Prevention Program
- Identify levels of combative behavior and recognize appropriate responses for each

1.4 Course Outline

This introductory lesson gave the course rationale and goals.
Lesson 2 discusses violence in the healthcare setting. This includes risk factors for violent patient behavior.
Lesson 3 presents the key parts of a Workplace Violence Prevention Program.
Finally, lesson 4 describes how to deal with aggressive behavior in the workplace.

2. Violence in the Healthcare Setting

2.1 Introduction & Objectives

Welcome to the lesson on the risk of violence in the healthcare setting.
After completing this lesson, you should be able to:

- Recognize the main reason for the high rate of violence in the healthcare setting
- Identify who is at highest risk
- Recognize where and when the risk is highest
- List other risk factors for violence in the healthcare setting

2.2 How High Is the Risk?

Violence can happen in any workplace.
According to NIOSH:

- Each year, about 800 people are murdered while at work or on duty.
- Each year, 1.7 million people are victims of nonfatal workplace assaults.

Healthcare workers are at increased risk for workplace violence:

- About 50% of all non-fatal injuries occur in healthcare and social service organizations

The rates are probably higher due to underreporting.
http://www.cdc.gov/niosh/topics/violence/
http://www.osha.gov/Publications/osha3148.pdf

2.3 Why Are Healthcare Workers at Increased Risk?

Healthcare workers are not the only ones at increased risk for workplace violence.
For example, taxicabs and retail liquor stores are also at high risk. In these industries, the reason for violence is usually robbery.
In the healthcare setting, the main reason for violence is stress. Patients and their family members often feel frustrated, vulnerable, or out-of-control. All of these feelings can lead to violence.
Note: Patients are responsible for most of the violence in the healthcare setting. However, healthcare workers also may be violent toward one another. Members of the general public can be violent, as well.

2.4 Who Is at Greatest Risk?

Remember: Patients and family members under stress can be violent.
So, which healthcare workers are at highest risk of experiencing violence?
Workers with the most direct patient contact are at the highest risk.
These include nurses and nursing aides.
Also at risk are:

- Emergency responders
- Hospital safety officers
- All healthcare providers

2.5 When Is the Risk Greatest?

2.6 Where Is the Risk Greatest?

Violence can occur anywhere in the hospital setting.
Violence is most frequent in:

- Psychiatric wards
- Emergency departments
- Waiting rooms
- Geriatric units

http://www.cdc.gov/niosh/2002-101.html

2.7 What Are the Risks?

Victims of violence may suffer:

- Minor physical injury
- Serious physical injury
- Temporary or permanent physical disability
- Temporary or long-term psychological trauma or disability
- Death

Workplace violence also can affect the organization as a whole. Violence can lead to:

- Low morale
- High work-related stress
- High employee turnover
- Little trust in administrative personnel and coworkers
- Hostile working environment

2.8 Additional Risk Factors

Remember: Patient stress is the reason for most hospital violence.
Additional risk factors are:

- Intoxicated patients or visitors
- Patients with a history of violence
- Patients with certain psychiatric diagnoses
- Patients with access to firearms
- Understaffing, especially during mealtimes and visiting hours
- Long waiting times
- Overcrowded, uncomfortable waiting rooms
- Working alone
- Poor building design, including poorly lit halls, rooms, parking lots, and other areas
- Poor hospital security

- Staff who are not trained to prevent and deal with possible violence
- Unlimited public access to the facility

2.9 Review

2.10 Summary

You have completed the lesson on violence in the healthcare setting.
Remember:

- Healthcare employees are at risk for workplace violence.
- Patients cause most of the violence in the healthcare setting.
- Nurses and nursing aides are at highest risk of hospital violence. This is because they have the most direct patient contact.
- Risk of healthcare violence is increased when there is a lot of activity and patient contact. Risk is also high when patients feel frustrated, vulnerable, or out-of-control.
- Within hospitals, violence is most common on psychiatric wards, in emergency departments, in waiting rooms, and on geriatric units.
- Violence in the healthcare setting can have serious consequences.

3. Workplace Violence Prevention Programs

3.1 Introduction & Objectives

Welcome to the lesson on Workplace Violence Prevention Programs.
After completing this lesson, you should be able to:

- List the parts of a Violence Prevention Program
- Identify the role of each part

3.2 OSHA Recommendations

According to OSHA, all employers should have a Violence Prevention Program.
This program should:

- Decrease the danger of workplace violence.
- Decrease the severity of injuries caused by workplace violence.
- Track the organization's progress in decreasing workplace violence.

3.3 Components of Violence Prevention Programs

An effective Violence Prevention Program has the following parts:

- A written plan
- Management commitment
- Employee involvement
- Worksite analysis
- Hazard prevention and control
- Safety and health training
- Post-incident response
- Recordkeeping and evaluation

On the following screens, let's take a closer look at each part.

3.4 Written Plan

The written plan should describe all parts of the Violence Prevention Program.
The plan also should:

- State clear goals for preventing violence.
- State that workplace violence will not be tolerated.
- Encourage employees to report all violence.
- Encourage employees to keep records of violence.
- State that retaliation against employees who report violence will not be tolerated.
- Describe how police and other experts will play a role in facility security.

3.5 Management Commitment

Management must be committed to the Violence Prevention Program. Otherwise, the program cannot succeed.
Management should inform all staff members that violence will not be tolerated. Staff should feel confident that all reports of violence will be taken seriously.
Management also should:

- Protect both the physical and emotional health of employees. This includes medical and psychological follow-up for workers after a violent incident.
- Ensure both worker and patient safety.
- Make sure that security officers have the authority and resources they need to keep the facility safe.
- Hold security officers accountable for workplace safety.
- Make sure that workers who report violent incidents are safe from retaliation.

3.6 Employee Involvement

Employees also must be involved in the Violence Prevention Program. Otherwise, the program cannot succeed.
Many employees do not do their part when it comes to reporting violence.
Reasons for not reporting include:
Lack of reporting policies or procedures **Lack of reporting policies or procedures**
The Violence Prevention Program should give clear policies and procedures for reporting violence. Employees should know these policies and procedures. Employees also should participate in complaint or suggestion sessions to improve procedures.

Fear that the employer will retaliate or consider the employee ineffective at his or her job **Fear of retaliation or perception of poor job performance**
Management must inform employees of the following:

- Employees cannot always prevent workplace violence.
- Reporting violence helps make the workplace safer.
- Retaliation for reporting will not be tolerated.

Employees must understand the following:

- Reporting violence makes it possible to identify, address, and correct security problems.
- There will be no retaliation for reports.

A belief that violence is part of the job **Belief that violence is part of the job**
Management must inform employees of the following:

- Employees have the right to a safe working environment.
- Workplace violence will not be tolerated.

Employees must understand that they can help make the workplace safer, by reporting violence.
Click on each of the above barriers to reveal methods for overcoming that barrier.

3.7 Worksite Analysis

OSHA recommends a Threat Assessment Team.
Members of the Assessment Team analyze records, trends, staff surveys, and workplace security protocols. This analysis can help identify risk factors for violence.
Examples of risk factors might include:

- Violent, confused, or mentally unstable patients
- Combative or uncooperative patients
- Unsafe exam rooms (for example, rooms with furniture that could be used to trap an employee, or rooms with items that could be used as weapons)
- Understaffing
- High employee turnover
- Employee stress
- A lot of firearms in the community
- Being in a high-crime area
- Drugs and money in the facility pharmacy, making it a target for robbery

---

3.8 Hazard Prevention & Control (1)

The Threat Assessment Team identifies risk factors and hazards. The next step is to find ways to control these hazards.
For example:

- Inform patients that the facility has a zero-tolerance policy for violence.
- Chart and evaluate potentially violent behavior in patients. Use a reliable system for passing this information from one shift to the next.
- Identify patients with a history of violence (for example, by obtaining past records).
- Make sure that all violence is reported right away.
- Train staff to recognize and deal with hostile and violent behavior.

3.9 Hazard Prevention & Control (2)

Other hazard controls might include:

- Better visibility and lighting, especially in high-risk areas
- Metal detectors to keep handguns out of the facility
- Plexi-glass windows in the pharmacy
- Security devices: panic buttons, beepers, surveillance cameras, alarm systems, two-way mirrors, card-key access systems, security guards
- Curved mirrors to show concealed areas
- Better staffing, especially in high-risk areas
- Escorts or shuttle service to and from parking lots and public transportation

---

3.10 Hazard Prevention & Control (3)

Finally, hazards should be controlled in exam rooms.
In rooms used for risky patients:

- Furniture should be lightweight or nailed to the floor. Furniture should not have sharp corners. This prevents the patient from using furniture to trap or attack staff members.

- Countertops should be kept clear. This prevents the patient from finding possible weapons.
- The room should have a back door. This gives staff members an escape route if the patient blocks the main door.
- Do not enter a room alone if you think a patient may become violent. Take a staff 'buddy.'

3.11 Health & Safety Training

Safety training decreases the risk of violence.
Trained staff members know:

- Warning signs that a person may become violent
- How to calm a person down before violence breaks out

Training will be discussed in greater detail in the next lesson.

3.12 Post-Incident Response

After a violent incident, employees may feel traumatized.
Employers should offer support.
This support should include:

- Medical care
- Psychological evaluation
- Any necessary follow-up (counseling, support groups, stress debriefing, trauma counseling, employee assistance)

3.13 Evaluation & Recordkeeping

It is important to keep records of violence:

- Records can be used to evaluate the Violence Prevention Program.
- Security problems can be identified.
- Problems can be corrected.

OSHA's Recordkeeping Rule requires employers to keep records of any work-related injury that results in:

- Death
- Days away from work
- Work restrictions
- Job transfer
- Medical treatment beyond first aid
- Loss of consciousness
- Diagnosis of a significant injury or illness

OSHA further recommends keeping records of:

- Workplace violence that does not result in injury
- Employee training on security and workplace violence
- Patients with a history of violence

3.14 Review

Reporting a violent incident is a good way to show your boss that you do not know how to do your job.

True
False
Select the answer that best fits the question.

3.15 Summary

You have completed the lesson on Workplace Violence Prevention Programs.
Remember:

- All employers should have a Violence Prevention Program.
- A written plan should describe each part of the Program. The written plan also should clearly state the employer's goals and policies.
- Management must be committed to the Violence Prevention Program. Employees must be involved. This includes reporting all violent incidents.
- A Threat Assessment Team should analyze the worksite. This analysis can help identify risk factors for workplace violence.
- Hazard controls can help reduce the risk of workplace violence.
- Staff should be trained on methods for calming situations down before violence breaks out.
- Employers should offer full support for workers after a violent incident.
- Records of workplace violence should be kept. This makes it possible to evaluate the Violence Prevention Program.

4. Recognizing and Responding to Combative Behavior

4.1 Introduction & Objectives

Welcome to the lesson on recognizing and responding to combative behavior.
After completing this lesson, you should be able to:

- Recognize signs of escalating combative behavior
- Identify appropriate responses to each level of behavior

4.2 Safety Training

Remember: Safety training is a key part of a Violence Prevention Program.
Training may include:

- An explanation of the Violence Prevention Program
- An explanation of how to report workplace violence
- Methods and skills for dealing with violent and potentially violent people

Violence Prevention Programs and reporting procedures have details that are facility-specific. Check with your supervisor if
you need more information.
This lesson will focus on how to recognize and respond to a threatening situation.

4.3 Dynamics of Combative Behavior

Remember: Patients often feel frustrated, vulnerable, and out-of-control. Anyone can lose control and become violent.
These **feelings** can easily intensify. As a result, the patient's hostile **behavior** is likely to intensify.
Hostile behavior tends to intensify (or escalate) through three levels:

- Tension
- Disruptiveness
- Violence

Let's take a closer look at each level.

4.4 Tension: Recognition

A tense person is frustrated and highly sensitive.
The person may express one of the following beliefs:
I am being threatened. ***I am being threatened.***
A patient might use body language to express this belief. This can take one of two forms:

- Defensive body language: huddled, muscles tensed
- Aggressive body language: upright posture, moving forward, pacing, clenching teeth, clenching fists

I am being deprived. ***I am being deprived.***

A patient might make statements that express this belief. For example:

- *'I've been waiting an hour. Three patients have gone in to see the doctor ahead of me!'*
- *'My daughter is really sick. You people aren't doing a thing about it!'*

My requests are being ignored. ***My requests are being ignored.***
A patient might make statements that express this belief. For example:

- *'I told you, I don't need to see the doctor! I just need a prescription for penicillin!'*
- *'My son can't wait any longer. I told you he needed to see the doctor right away!'*

Click on each of the above for ways in which a patient might express each belief.

4.5 Tension: Response

When a patient is tense:
Remain calm, quiet, rational, and professional. **Remain calm, quiet, rational, and professional.**
This response can help calm things down. Remember not to take tense behavior personally! In most cases, you are not responsible for the person's frustration. You are simply the target. Do not get into a power struggle.
Apologize. **Apologize.**
Use an apology to show sympathy. This can help calm the person down. It also encourages cooperation. Consider an apology such as: *'I'm sorry you've had to wait so long. I know that's frustrating.'*
Listen and ask questions. **Listen and ask questions.**
Show that you are interested and concerned by listening respectfully. Then ask follow-up questions. Again, this can help calm the situation. The person sees that he or she does not need to act even more aggressively to get your attention.
Summarize. **Summarize.**
You meet two goals when you sum up what you have heard the person say. First, you make sure that you have understood correctly. Second, you continue to show that you are interested and concerned. This continues to soothe the person's feelings of being ignored and deprived.
Address the problem. **Address the problem.**
In this final step, state the problem. Ask the person to help you find a solution. You may need to bring in a supervisor or someone else who can help. Decide what you can do. Then let the person know.
Never promise more than you can do!
Click on each of the above techniques to learn more.

4.6 Disruptiveness: Recognition

If a tense person is not calmed down, that person may become disruptive.
A disruptive person:

- May use rude language
- May make verbal threats
- Does not think rationally
- Will not calm down easily

4.7 Disruptiveness: Response

When responding to disruptive behavior:
Stay calm. Choose your words carefully. **Stay calm. Choose your words carefully.**
Stay calm to help calm the situation. Think about your choice of words. Certain words and phrases are likely to make the person even more angry. These include, *have to*, *can't*, and *it's not our policy*.
Instead, use words and phrases such as: *I will..., will you..., and would you be willing...*
Give clear instructions. Set clear limits. **Give clear instructions. Set clear limits.**
Explain that you will not be able to help until the person stops certain behaviors (for example, swearing or making verbal threats). Be polite, but clear and firm. Continue to choose your words carefully.
Continue to show that you want to help. **Continue to show that you want to help.**
Listen. Ask questions. Summarize.
NEVER touch the person. **NEVER touch the person without their approval.**
Even a gentle touch can feel like an attack to a person who is very upset. The person may respond violently. Keep your distance.
Signal for help. **Signal for help.**
An open call to security may make things worse. Signal for help without letting the person know. Do not hesitate to do this.
Click on each of the above methods to learn more.

4.8 Violence: Recognition

Violence is the most dangerous level of combative behavior.
The person may:

- Yell
- Scream
- Become physically violent
- Use a weapon

4.9 Violence: Response

If a person becomes violent:

- Do NOT confront the person.
- Do NOT try to stop the person physically.
- Get yourself and others to safety.
- Call security and the police.

4.10 Reporting

Report all violence right away.

4.11 Review

4.12 Summary

You have completed the lesson on recognizing and responding to combative behavior.
Remember:

- The levels of hostile behavior are tension, disruptiveness, and violence.

- Tense people are frustrated and highly sensitive. They feel threatened, deprived, or ignored.
- Respond to tension by staying calm, apologizing, listening, asking questions, summarizing, and addressing the problem.
- Disruptive people are verbally abusive, irrational, and difficult to calm down.
- Respond to disruptive behavior by staying calm, choosing your words carefully, setting clear limits, showing that you want to help, and secretly calling for security. Never touch a disruptive person.
- Violent people yell, scream, act physically violent, and may use weapons.
- Respond to violence by getting yourself and others to safety. Then call security or the police. Never try to stop a violent person physically.

Exam

Examination Summary

- This examination contains **20** question(s).
- You must answer **80%** correctly or **16** out of **20** question(s) in order to pass this examination.
- Use Next/Previous rather than the scroll bar.
- Do **NOT** click the **X** on the upper right-hand corner of the window.
- Please answer all questions below, then click the SUBMIT button at the bottom of the page to have your examination scored.
- This assessment is not timed.

Question 1 of 20

According to Mountain View's "Code Green" policy, who is expected to respond to a code green?

Answers

- ○ The police
- ○ All available maintenance/security employees and any other available employees
- ○ All available nurses
- ○ All available men

Next

Question 2 of 20

Within the healthcare setting, violence is most frequent in certain areas. One of these areas is:

Answers

- ○ The lab
- ○ Waiting rooms
- ○ The maternity unit
- ○ The pediatric department

Previous Next

Question 3 of 20

With regard to violence in the healthcare setting, plexiglass windows in the pharmacy are an example of:

Answers

- ○ An irrelevant item
- ○ A risk factor for violence
- ○ An unsafe facility design
- ○ A violence hazard control

Previous Next

Question 4 of 20

If a Code Green is called, the patient will need to be restrained

Answers

- ○ True
- ○ False

Previous Next

Question 5 of 20

What code would you call at Mountain View to receive help with a possible hostile patient or customer?

Answers

- ○ Code Yellow
- ○ Code black
- ○ Code Red
- ○ Code Green

Previous Next

Question 6 of 20

Following a "Code Green" the Team Leader must complete an occurrence report:

Answers

- ○ Before the end of the shift
- ○ Within the next hour
- ○ When he/she returns for their next shift
- ○ Within 48 hours

Previous Next

Question 7 of 20

According to Mountain View Hospital's policy, when restraining a patient, the restraints must be tied tight enough to prevent movement of torso, pelvis of extremities.

Answers

- ○ True
- ○ False

Previous Next

Question 8 of 20

Please check all that apply. It is the policy of Mountain View Hospital to:

Answers

- ☐ Restrain a patient as soon as he/she becomes belligerent.
- ☐ Prevent, reduce, and eliminate the use of restraints
- ☐ Protect the patient and preserve the patient's rights and dignity
- ☐ Assume total care of any patient in restraints

Previous Next

Question 9 of 20

A person begins to act out physically, shoving chairs and pounding the reception desk. Which level of hostile or combative behavior does this indicate?

Answers

- ○ Tension
- ○ Violence
- ○ Disruptiveness

Previous Next

Question 10 of 20

A risk factor for violence in the healthcare setting is:

Answers

- ○ Adequate staffing
- ○ Intoxicated patients or visitors
- ○ Short waiting times for patients
- ○ Limited public access to the facility

Previous Next

Question 11 of 20

When a person becomes violent, which of the following is the best response?

Answers

- ○ Ignore the person
- ○ Confront the person
- ○ Stop the person physically
- ○ Get yourself and others to safety

Previous Next

Question 12 of 20

The healthcare workers at HIGHEST risk of experiencing violence are:

Answers

- ○ Physicians
- ○ Hospital safety officers

○ Emergency responders
○ Nurses and nursing aides

Previous Next

Question 13 of 20

At Mountain View Hospital, you dial a '3333' to call a code green overhead.

Answers

○ True
○ False

Previous Next

Question 14 of 20

Consider OSHA requirements related to workplace violence and injury. OSHA's Recordkeeping Rule REQUIRES employers to keep records of:

Answers

○ Patients with a history of violence
○ Employee training on security and workplace violence
○ Work-related injury that requires treatment beyond first aid
○ Any workplace violence, whether or not serious injury results

Previous Next

Question 15 of 20

Worksite analysis is one part of a Violence Prevention Program. The goal of worksite analysis is:

Answers

○ To identify risk factors for violence
○ To identify patients who should be placed in restraint
○ To identify how poor job performance contributes to violence
○ To identify employees who should be disciplined for reporting violence

Previous Next

Question 16 of 20

Please check all that apply. According to the Mountain View "Code Green" policy, the assistant is to help by:

Answers

☐ Calling the police
☐ Being stern with the disruptive patient
☐ Removing visitors
☐ Answering phones

☐ Unlocking the door or guarding the door

Previous Next

Question 17 of 20

Please check all that apply. The Occurrence Report documents:

Answers

☐ Justification for the code
☐ Appropriateness of interventions and alternatives
☐ The opinion of the team leader as to why the patient "lost it."
☐ The frustration and anger experienced by the staff when the patient became belligerent

Previous Next

Question 18 of 20

When a person becomes disruptive, which of the following is the best response?

Answers

○ Ignore the person
○ Pat the person on the back reassuringly
○ Tell the person everyone else has problems, too
○ Give clear instructions and set clear limits for behavior

Previous Next

Question 19 of 20

Please check all that apply. According to Mountain View's restraint policy, alternatives to the use of physical restraints may include:

Answers

☐ Using a sitter if appropriate
☐ Tranfering patient to a room near the nurse's station
☐ Involving the family in monitoing of the patient
☐ Distract or redirect the patient

Previous Next

Question 20 of 20

The second level of hostile or combative behavior is disruptiveness. A sign of disruptiveness is:

Answers

○ Verbal threats
○ Use of a weapon
○ Yelling or screaming

○ Defensive body language

Previous

Close Pause Submit

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O:HLCWEB3 A:HLCWEB3 C:CONTENT7

TAB 3

SEC 3

[redacted]

From: info@crisisprevention.com
Sent: Friday, April 09, 2010 1:48 PM
To: [redacted]
Subject: CPI Seminar Registration Confirmation

Thank you for registering for a Crisis Prevention Institute Seminar. Below is your seminar registration information. Registration is limited and is processed on a first-come, first-served basis. We will mail your confirmation within 7-10 days after you register. If the program you would like to attend is full, you will be notified and can request to be put on a waiting list.

Program:*Nonviolent Crisis Intervention*

Location: Boise,ID 04/19/2010 - 04/22/2010

Organization Information
Contact Person: [redacted]
Job Title: Post-Surg Supervisor
Name: Mountain View hospital
Address: 2325 Coronado St.
City: Idaho Falls
State: Idaho
Zip: 83404
Country: USA
Phone: [redacted]
Fax:
Email: [redacted]
Participant Information

Participant 1
Name: [redacted]
Title: Post-Surg Supervisor
Program: 4-Day Instructor Certification
Instructor ID:

Amount Billed
4-Day Instructor Certification $1529 1 participant(s) $1529

Final Total: $1529

Payment Method: [redacted]

Please make sure to fax or email your tax exemption certificate to 1-262-783-5906 or email to info@crisisprevention.com

[redacted]

From: Holiday Inn Reservations [HolidayInn@reservations.ihg.com]
Sent: Friday, April 09, 2010 1:57 PM
To: [redacted]
Subject: Your Holiday Inn (R) Reservation Confirmation - BOISE, ID, UNITED STATES: 67241352

Modify/Cancel Reservation
View All Reservations
Make Another Reservation
View Account

Thank you for staying at the Holiday Inn BOISE-AIRPORT.

Amenities
Indoor Pool
Pets Allowed
Whirlpool
On-site Guest Self-Laundry Facilities
Kids Eat Free

Attractions
Downtown Boise
Boise Town Square Mall
Boise State University-Pavillion
Boise Factory Outlet Mall
Birds of Prey Sanctuary

Earn bonus points or miles EVERY NIGHT you stay! Earn 1,000 bonus points or 200 bonus miles every qualifying night you stay - up to 20,000 points or 4,000 miles.

Thank you for choosing Holiday Inn. Here is your reservation information.

Reservation Questions

Reservation Information

Your confirmation number is [redacted]
Please use your confirmation number to reference your reservation.

Guest Name:
[redacted]

Additional Guests:
No additional guests.

Check-In: Sun 18 Apr 2010 at 03:00 PM
Check-Out: Thu 22 Apr 2010 at 12:00 PM

View/Modify/Cancel Reservation

Hotel Info

Hotel Lobby

BOISE-AIRPORT
Holiday Inn
3300 VISTA AVENUE
BOISE , ID 83705
208-343-4900

Helpful Links
Local Maps
Find Attractions
Make Another Reservation

Driving Directions:
AT I-84 & VISTA AVENUE, EXIT 53

Room/Rate Information

Rate Type:	Best Flexible Rate
Rate Description:	Our Best Flexible Rate lets you stay for as many nights as you want, on any date you please, with the best flexible rate available at all of our hotels around the world. Our Best Flexible Rate is the best available unrestricted, publicly available rate for that room type at the time of reservation. While lower rates may be available, they will require payment at time of booking, a minimum length of stay or will be non-refundable. Some restrictions apply based on individual hotel policies.
Room Type:	1 KING BED LEISURE NONSMOKING - 5 PERSON(S) MAX PER ROOM WITH ALL UPDATED DECOR HIGH SPEED INTERNET TABLE W CHAIRS ON COMMAND MOVIES INTERIOR CORRIDORS HAIR DRYER COFFEE W COFFEEMAKER
Smoking Preference:	Non-Smoking
Number of Nights:	4

Number of Rooms: 1

Person(s): 1 Adult(s), 0 Child(ren)

Sun 18 Apr 2010 - Thu 22 Apr 2010	$94.00 (USD) per night (1 room(s))
Total Tax †	$48.88 (USD)
Estimated Total Price †	$424.88 (USD)

Rules & Restrictions

- Check-in Time: 03:00 PM
- Check-out Time: 12:00 PM

- Canceling your reservation before 6:00 PM (local hotel time) on Sunday, 18 April, 2010 will result in no charge. Canceling your reservation after 6:00 PM (local hotel time) on 18 April, 2010, or failing to show, will result in a charge equal to the first night's stay per room to your credit card. Taxes may apply. Failing to call or show before check-out time after the first night of a reservation will result in cancellation of the remainder of your reservation.

- Only the reservation as entered into and confirmed by our system will be honored. Any written or printed confirmation that has been altered may be rejected by the hotel.

† As exchange rates may fluctuate from the time a reservation is made until the actual stay, the confirmed rate is guaranteed in the hotel's base currency.

† As taxes and service charges may fluctuate from the time a reservation is made until the actual stay and during the actual stay, the Total Price is an estimate. Other hotel-specific service charges may also apply. Check with hotel for details. Additional taxes may apply for hotels booked in Tokyo, Japan that exceeds 10,000JPY/person per stay.

† Credit card payments relating to Australian hotels incur a merchant service fee of 1.5% in addition to the total amount payable.

Important, please note: Starting June 1, 2009, the Western Hemisphere Travel Initiative (WHTI) goes into effect, establishing new document requirements for travel into the U.S. from Canada, Mexico, Bermuda and the Caribbean, by land and sea. All U.S., Canadian and Bermudian citizens are subject to these new requirements, effective June 1, 2009. For more information about the WHTI and the required travel documents, go to www.GetYouHome.gov or Canadian citizens can go to www.KnowYourBorder.gov.

Comments:

- For Reservations Questions in the United States & Canada:

1 800 HOLIDAY (800 465 4329)

- For outside the United States & Canada, click here

TAB 3

SEC 4

Restraints may only be imposed to ensure the immediate physical safety of the patient and/or others to prevent harm.

Restraints use is considered an exceptional event and not a routine response to certain patient conditions or behaviors. Each patient will be assessed for their individual needs.

PURPOSE

Mountain View Hospital's goal is to use the minimal amount of restraints as possible to achieve the highest quality of safety for patient and medical staff. The use of restraints is an intervention implemented to prevent the patient from injuring himself/herself or from injuring others. Every effort is taken to protect patient rights, dignity and well-being at all times. This policy is used to provide consistent guidelines for the safe use of chemical and physical restraints, if other alternatives, as determined by an interdisciplinary team, have prove clinically ineffective to provide a safe environment for the patient.

DEFINITIONS

Alternative interventions: Measures that modify the patient's environment enhance interpersonal interaction; or provide treatment so as to minimize or eliminate the problem behaviors that place the patient at risk for injury to self or others.

1. Restraint: is any manual method, physical, chemical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his/ her arms, legs, body, or head freely. The types of restraint devices include: soft wrist restraints, hand mitts if tied down and vest restraints and lap belts. Situations considered restraints are:

    1.1. Tucking sheets in tightly that prevent patient movement.

    1.2. Use of all four side rails preventing patient from voluntarily getting out of bed.

    1.3. Recliners if the patient cannot easily remove the restraint appliance and get out on their own.

    1.4. Arm board if it is tied down or attached to the bed frame or the entire limb is immobilized so the patient cannot access his or her body.

    1.5. Physically holding a patient in a therapeutic hug

    1.6. Holding a patient down to give or administer a medication against the patients will.

2. The following situations are not considered a restraint under this policy. Devices in this category can be easily removed by the patient and/or are age or developmentally appropriate:

    2.1. Standard practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures and the related post procedure care processes (for example, surgical positioning, intravenous arm boards (not tied to the bed frame), radiotherapy procedures,

protection of surgical and treatment sites in pediatric patients.

2.2. Adaptive support in response to assessed patient need (for example, postural support, orthopedic appliances that are released at the patient's request.

2.3. Age or developmentally appropriate protection like strollers, safety belts or high chair belts. Placement in a crib with raised rails is an age appropriate standard for infant and toddlers.

2.4. Measures taken to protect the patient from falling out of bed that are removed at the patient's request.

2.5. Helmets

3. When the action or device is used for safety purposes such as but not limited to: Forensic and correction restrictions used for security by law enforcement officials

3.1. Physical escorts with a light grasp to escort the patient to desired location, if the patient can easily move away from the grasp.

3.2. If the patient requests assistance to be held still for an injection or a procedure to safely administer an injection or an intravenous line.

3.3. If a patient is on a bed that constantly moves to improve circulation or prevent skin breakdown and raised rails are a safety intervention to prevent the patient from falling.

3.4. When a patient is placed on seizure precautions and all side rails are raised and padded for their protection.

3.5. When a patient is on a narrow, elevated mobile stretcher used to transport patients and to evaluate or treat patient the use of side rails in not considered a restraint but safety intervention.

4. Medical restraint: is the restriction of a patient's movement for the management of a medical diagnosis related condition in which the patient could be classified as irrational, uncooperative or interfering or disrupting the efforts of the medical personnel to provide medical care for some procedures (i.e. attempting to remove an endo tracheal tube, removing an IV line, pulling at foley catheters or NG tubes). The clinical assessment determines that these conditions are usually temporary and a result of the medical condition and the medical restraint is justified as an effort to preserve the well-being and condition of the patient. When medical restraints must be applied, it is to directly support medical healing.

5. Seclusion: is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. This type of restraint is not a practice of Mountain View Hospital.

6. Chemical Restraint: A medication used to control the behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition. Chemical restraints may only be administered by a nurse who has training and knowledge in the safe and effective administration of the chemical restraint prescribed to include normal dose, maximum dose in 24 hours, side effects, interaction with the patient's other therapeutic medications. The pharmacist is available as a reference for the nurse's review as well as the Physician's Desk Reference prior to administration. If further clarification is required, the physician should be contacted for clarification. All orders for antipsychotics, sedatives (barbiturates and nonbarbituates), tranquilizers, anxiolytics, and anesthetic general injectable medication require documentation of dose, route, frequency, and medical indication. The pharmacist or nurse prior to administration will clarify any orders that do not contain this information. The use of PRN or standing order drugs or medications is prohibited if used as a restraint.

7. Attending physician: is any physician responsible for the care and treatment of the patient or his/her physician designee, this includes a licensed independent practitioner (LIP), such as a physician assistant or nurse practitioner, working under the direction of the attending physicians.

POLICY

It is the policy of Mountain View Hospital to:

1. Prevent, reduce and eliminate the use of restraints by:

1.1 Preventing emergencies that have the potential to lead to the use of restraints

1.2 If an emergency exists, refer to the code green policy

1.3 Provide a physical assessment to identify medical problems that may be causing behavior changes in the patient such as elevated temperature, hypoxia, hypoglycemia, electrolyte imbalances, and drug interactions.

1.4 Limit the use of restraints to emergencies where there is a risk of the patent harming him/her or others.

1.5 Using the least restrictive method possible.

2. Protect the patient and preserve the patient's rights, dignity and well-being during restraint use by:

2.1 Respecting the patient as an individual

2.2 Maintaining a clean and safe environment

2.3 Encouraging the patient to continue to participate in own care

2.4 Maintaining the patient's modesty, preventing visibility to others, and maintaining a comfortable body temperature.

3. Provide for safe application and removal of the restraint by qualified staff. Discontinued as soon as possible based on an individualized patient assessment and re-evaluation.

4. Monitor and meet the patient's needs while in restraints at least every 2 hours monitoring for signs and symptoms of injury, meeting nutrition and hydration needs, performing range of motion and circulation checks, vital signs as appropriate and determine if less restrictive methods are possible.

5. Reassess and encourage release of restraints as soon as possible.

6. A restraint is never used for reasons of discipline or staff convenience.

Alternatives to the use of physical restraints may include:

1. Increased level of staff observation

2. Distraction and/or redirection techniques

3. Transfer to room in closer proximity to nurses' station

4. Involve family in monitoring of patient

5. Use of a sitter if appropriate

Note that restraints are not intended as an intervention for patient fall prevention.

Persons will not be restrained in a prone position

Reporting adverse events

Staff shall complete a variance report for any injury or death that occurs while a patient is Restrained, or where it is reasonable to assume that a patient's injury/death is a result of restraint. Staff shall immediately notify the administrator/Administrator on call of any death that occurs while a patient is restrained or where it is reasonable to assume that a patient's death is a result of a restraint.

The hospital shall report to the CMS Regional Office any death that occurs while a patient is restrained for the management of unanticipated severely aggressive behavior. This report shall be made by the next business day following the patient's death. Staff shall document in the patient's medical record the date and time the death was reported to CMS.

Leadership demonstrates its commitment to the aforementioned by providing and/or promoting:

1. Ongoing staff orientation and training

2. Patient and family education, as appropriate

3. The development and promotion of preventive strategies

Note: This policy does not apply to devices used for positioning/securing, voluntary mechanical support (CPM) or used by law enforcement officials although the standards of care stated within this document may be applicable.

Clinical Justification for use of restraints

When clinically indicated, the restraint procedure is implemented by an RN who is trained in restraint technique upon a physician/Licensed independent practitioner order. Unless there is an immediate and overriding concern for safety, the procedure is utilized only after all alternative, less restrictive treatment interventions have been tried without success.

The ordering physician will perform a visual assessment of patient within 30-60 minutes upon initiating restraints. This assessment will be included in the medical record.

Using the restraint flow sheet for patient behaviors and alternatives for use of restraints, clinical assessment and utilization of restraint should be based on patient's behavior that may place the patient or others at risk for harm.

Situations in which restraints are clinically justified include:

1. Harmful to self or others as evidenced by hitting, hair pulling striking at or biting staff or family, and self-mutilation, and appropriative measures have been attempted.

2. Threatens placement and/or patency of necessary therapeutic lines/tubes, interfering with necessary medical treatment, and appropriate alternative measures have been attempted. Examples include self-removal of IV lines, NG tubes, ET tubes, Foley catheter, complex dressings, and picking at open wounds or incisions.

3. Unable to follow directions to avoid self-injury, and appropriate protective, alternative measures and been attempted. Examples are climbing out of bed wandering in rooms or hallways without the strength or cognitive ability to safely do so.

Available types of restraint devices available within MVH in order of less restrictive to more restrictive are:

1. Side rails-when all 4 are raised to restrain the patient

2. Arm splints-not limiting to allow line protection

3. Mitts 1 or 2- allows fingers to move freely to protect lines- is a restraint when tied down.

4. Vest restraint or Lap belt- to allow as much movement for the patient as possible.

5. Leather restraints are not a practice at Mountain View Hospital

PATIENT CARE MANAGEMENT

Note: Physical restraints may be contraindicated in the care of a patient with the following conditions or under the following circumstances:

- The patient is actively hallucinating or is delusional.
- The patient has a physical impairment or injury with significant potential that use of mechanical restraints could cause exacerbation of the impairment of injury
- The patient has a history of sexual abuse. In this instance, if mechanical restraint is deemed necessary, complete consideration should be given to restraining the patient's legs together and to the gender of the staff implementing the procedure.
- The use of mechanical restraints increases the patient's agitation

1. A physician or LIP is responsible for ordering the use of a medical or chemical restraint. If restraints are needed the physician or LIP will be contacted for a telephone order to initiate the restraints. The physician will then provide a face to face evaluation within 30-60 minutes of initiating the restraint.

2. The physician or LIP ordering the use of a chemical restraint is to treat a specific patient's clinical condition based on the patient's symptoms, clinical situation and enables the patient to be more effective or appropriate in their actions.

3. Upon initiation of restraints and obtaining a verbal or written order as soon as possible, not to exceed 30 minutes after initiation from an RN. An assessment will be done by the RN within 15 minutes of the first application of the restraint then again in 1 hour then every 2 hours or as needed. A chemical restraint will also have a sedation level assessed every 1 hour and every time a dose of medication is given and document on the restraint flow sheet accordingly.

4. If chemical restraint, the Pharmacist must verify that the chemical restraint is used within the pharmaceutical parameters approved by the FDA and/or reviewed by the Pharmacy and Therapeutics Committee for the indications that it is manufactured and labeled to address, including listing dosing parameters and that it follows the national practice standards recognized by the medical community.

5. If chemical restraint, the RN will notify the Pharmacist and document the name of the pharmacist contacted along with the date and time on the restraint flow sheet.

6. A physician or LIP will perform a physical evaluation of patient prior to each 24 hour renewal of a restraint order

7. If a continued need for a restraint is clinically justified a renewal of the original order will be given by the physician or LIP not to exceed 24 hours from the initial order time.
8. Maintain:

    8.1 a safe method for patient to obtain help/notify care provider of needs

    8.2 update plan of care which would include the restraint management

    8.3 The plan of care must include Time/Date the restraint was initiated and why the restraint is being used also who performed the face to face evaluation.

    8.4 Focus on elimination problem that caused need for restraints.

    8.5 Intact, clean restraints by replacing them when soiled, broken or at risk for failure.

    8.6 Communication with family/significant other (notify them promptly upon initiation of restraints in cases where the individual wants his and her family notified, and the family has agreed to be contacted).

9. Promote the following every 2 hours, and as needed

    9.1 Psychosocial comfort

    9.2 Position changes and provide range of motion activities unless contraindicated by patient behavior, physical condition, clinician judgment

    9.3 Nutrition, hydration, hygiene, and toileting.

10. Remove restraints when patient is no longer at risk or when alternatives are successful.

11. Document restraint use in the Restraint Log on Post-Surgical floor. Notify Restraint Coordinator via e-mail, or file an occurrence.

REPORTABLE CONDITIONS

1. Notify physician or licensed independent practitioner for any of the following:

    1.1 Immediately if patient's condition is significant change from baseline.

    1.2 Ineffectiveness of the restraint intervention

1.3 Dislodgement of lifesaving equipment

1.4 Functional decline

1.5 Complications of prolonged immobilization

1.6 Any injury to patient

2. Notify clinical leadership (unit manager or supervisor, Risk management, or Director of Nursing) of injury or death where it is reasonable to assume that it may be a result of restraint use.

PATIENT/SIGNIFICANT OTHER EDUCATION

1. Teach:

1.1 Reason for application or use of restraint

1.2 Anticipated length of use

1.3 Safe method to obtain help/notify care provider of needs

1.4 Criteria for release

1.5 Care that will be provided to reassure patient/significant other (patient will be checked frequently, have his or her personal needs met, be released from restraints as quickly as possible).

SAFETY

1. Implement the following safety measures:

1.1 Apply restraint with room to insert on finger under the device; allow enough slack for the patient to move torso, pelvis, or extremity up to 2 inches.

1.2 Secure restraints to the parts of the bed that move with the patient, never to the mattress or side rail.

1.3 Utilize appropriate number of staff (minimum of 2 people) and appropriate safety techniques whenever a restraint is released and during transfer of the patient to a safe environment

1.4 Remove potentially harmful items from the patient/patient care area (i.e. sharps, glass).

1.5 The mechanical restraint will be tied in an easy release method of just one loop to ensure quick release when the tail of the loop is pulled.

1.6 Release patient from all restraints in emergency situation, according to Mountain View Hospital evacuation plan.

GUIDELINES

1. Providing psychosocial comfort in patient with restraints

1.1 Communicating verbally with the patient

1.2 At least every 2 hours allowing the patient to have their hands free to communicate in sign language or by writing.

1.3 Telling the patient when you plan to return when leaving the room

1.4 Doing what you say you're going to do

1.5 Coming back frequently for nonverbal patients.

TRAINNG FOR MEDICAL AND CHEMICAL RESTRAINTS

1. All restraint training is supervised by the restraint coordinator whom has completed a formal training program.

2. All RN/LPN staff will complete a mandatory training of restraints on Health stream upon hire and annually.

3. Physicians who order medical or chemical restraint shall be trained on the requirements of this policy and there shall be a review of all restraint orders by the Safety Committee.

4. All members expected to respond to a code green will receive training, in the following subjects as it relates to their duties performed under this policy. Such training shall take place during new employee orientation, and on a periodic basis as indicated by the results of quality monitoring activities.

4.1. Techniques to identify patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint.

4.2. The use of non-physical intervention skills and techniques before restraint use.

4.3. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status condition.

4.4. The safe application and use of all types of restraint used by the staff member, including training in how to recognize and respond to signs of physical and psychological distress.

4.5. Recognizing signs of any incorrect application of restraints.

4.6. Identifying underlying causes of threatening behaviors exhibited by the patient and how staff can affect the behaviors.

4.7. De-escalation, mediation, self-protection techniques.

4.8. Staff shall recognize age, developmental considerations, gender issues, ethnicity, language barriers, and the way the patient reacts to physical contact.

5. Staff members who apply restraints and monitor patients in restraints will receive training in:

5.1. Taking vital signs and interpreting their relevance to the physical safety of the patient in restraint.

5.2. Recognize nutritional and hydration needs.

5.3. Checking circulation and range of motion in the extremities.

5.4. Addressing hygiene and elimination.

5.5. Addressing physical and psychological status and comfort.

5.6. Recognize readiness and helping patients meet behavior criteria for discontinuing restraint.

5.7. Recognize when to contact medically trained LIP services to evaluate and or treat the patient's physical status.

5.8. The application and removal of mechanical restraints.

5.9. Identify specific behavior changes that indicate the restraint is no longer necessary.

5.10. Use of MVH policy and obtaining physicians or LIP orders.

5.11. Appropriate documentation of medical or chemical restraint use in the patient's medical record as appropriate.

TAB 3

SEC 5

MOUNTAIN VIEW HOSPITAL
Idaho Falls, Idaho

Patient Sticker

RESTRAINT DOCUMENTATION

Flow Sheet - 24 Hour Record

RESTRAINT INITIATED: DATE_____ TIME_____	FACE TO FACE with Dr.: DATE_____ TIME_____	RESTRAINT DC'D: DATE _____ TIME _____

SKIN	ROM	RESTRAINT MGT	POSITION	FLUID/NUTRITION/TOILET	PATIENTS RESPONSE	RESTRAINT TYPE	LOC
I - Intact R - Reddened B - Broken (see Nurses Notes) M - Mottled	Y - Yes N - No S - Sleeping AM - Ambulate	A - Apply R - Release R/A - Release/Apply	O - Out of Bed R - Right side L - Left side S - Supine	F - Fluids N - Nutrition T - Toilet	C - Calm AG - Agitated S - Sleeping	C - Chemical V - Vest S - Soft arm R - Roll belt B - Bedrails X 4 M - Mitts	A - Alert S - Sedated O - Orientated C - Confused B - Belligerant

* ***If Chemical Restraint used contact Pharmacy***

Pharmacist contacted _____ Date: _____ Time:_____
Name

TIME EVERY 1 HOUR																								
Skin/ Circulation																								
Range of Motion																								
Restraint Management																								
Position																								
Fluid/Nurishment/Toilet Offered																								
Patient Response to Restriant																								
Type of Resrtraints																								
LOC/Psychological Status																								
Alternatives to restraints attempted YES/NO																								
Patient Assessment/Plan of Care Reviewed																								
Staff Initials																								

Renew Restraint Order with-in 24 Hours

Initial	Signature	Initial	Signatures	Initial	Signatures

TAB 3

SEC 6

RESTRAINT LOG AUDIT

Patient Account Number: _____ Medical Record Number: _____ Auditor Name _____

Restraint Type: _____

	YES	NO	Explanation
Was face to face evaluation done within 30/60 min of initiation?			
Was hourly documentation completed?			
Were discharge orders received?			
If Chemical restraint used was there a pharmacy review completed?			
Were alternatives to restraints attempted?			
Was renewal order done with-in 24 hours?			

TAB 3

SEC 7

	DEPARTMENT: Hospital Wide		CHAPTER: Security	
	POLICY: Code Green			
	APPROVED DATE: 4/09/2010	REVISED DATE: 4/09/2011	POLICY #: 1012	Page 1 of 2

POLICY

It is the policy of Mountain View Hospital to initiate a "CODE GREEN" whenever there is a crisis management situation that requires additional assistance beyond that readily available. All engineering staff member and all other available staff members shall go to the location.

PURPOSE

To assure the prompt arrival of additional assistance; provide a "show of force" to contain an aggressive, out of control patient; to prevent a patient from injuring his/her self; prevent the use of restraint, or to obtain other staff members necessary to authorize the use of restraint (R) in the event this becomes necessary.

APPLICABILITY

Applies to all patient related areas.

PROCEDURE

1. Initiating a Code Green **does not** mean automatic restraint. If the patient responds positively to the team "show of force" by calming down and responding to verbal direction, then restraint is not indicated.

2. Upon identification of a crisis situation/emergency in a clinical area, the person in charge of the unit is responsible for making the decision to initiate a code green. In the absence of a Registered Nurse, a Licensed Practical Nurse, or other clinical staff may make the decision. For off-unit occurrences, the individual in charge of the event, e.g., any staff member may initiate the code.

3. A code green is initiated by dialing 2222 and stating "CODE GREEN (***specify location***)" three times. An all clear announcement authorizing clearance of the code will be called overhead when the issue is resolved.

4. The person announcing the page will announce "CODE GREEN ***(specify location)***" three times. All available clinical staff within the facility will report to the location stated.

5. A team approach will be utilized. The Team Leader is the RN or MD or other clinical staff who directs the team, initiates verbal intervention, determines the need for restraint, and gives the directive to release staff, especially if excess.

   5.1 Assistants help by:

   5.1.1. Removing/isolating and supervising other patients
   5.1.2. Verbal intervention
   5.1.3. Removing visitors
   5.1.4. Answering phones
   5.1.5. Unlocking the door or guarding the door
   5.1.6. Putting restraints on the bed
   5.1.7. Physical restraint (only if absolutely necessary) *refer to policy*
   5.1.8. Performing other actions as deemed appropriate by the Team Leader

6. As soon as the situation is under control, the person in charge will authorize the call to make the "All Clear" announcement. A member of the team will announce, "CODE GREEN ALL CLEAR" three times.

7. Following a "Code Green," the Team Leader must complete an occurrence report before the end of the shift (The form is available at each Nursing Station). The occurrence report documents the justification for the code and the appropriateness of intervention and alternatives. The occurrence report should be processed within 48-hours. It will be forwarded to the Compliance/Risk Management Department for monitoring and evaluation of effectiveness.

PLAN FOR CORRECTION FOR CONDITION OF PARTICIPATION, PHARMACY SERVICES
482.25 PHARMACEUTICAL SERVICES

CONDITION WILL BE MET BY POLICY EDUCATION AND MONITIORING OF MEDICATION.
Completion date: 4/19/2010

A491
Policy
Revised or created
Sample
medication
Management
"Redi Care
medication sample
management"

P&T Committee
Approved sample
process as long as
RX was part of
Redi-Care
formulary
4/7/2010

Board of
Managers
Policy approved
4/14/10

Redi-Care
samples will be
monitored and
check for dates
and logging
process

QA measures
Pharmacy will
review sample
medication log for
compliance and

A491
Completion date:
4/19/2010

A500
Pharmacist will review all
mediation orders
Policy:
"Medication, Storage, review
and inspection"
#2336

A500
CCN staff education on staff
meeting and mandatory read
email that all medication
orders must be faxed to
pharmacy per policy

Staff will be educated by
mandatory read email and
policy changes from Peri natal
committee
Information will be reviewed in
staff meetings

Restraint Flow sheet revised
to include documented
Pharmacist review
Of chemical restraint orders
Policy
Restraint
1010

P&T Committee approved IV
Haldol use with suggested
parameters
4/7/2010

P&T Committee approved a
pre printed sliding insulin
scale

QA measures
All Restraint and restraint log
will be reviewed by pharmacist
as a member of Safety
committee

A500
Completion date:
4/19/2010

A502 & A503
Education of current policies
Policy "Controlled substances
management" #2312

Staff education of policy
requirements
Via email and staff meetings

A502
Equipment change from locks
that require a turn to close to a
cabinet that will lock upon
closing

A502 A503
PACU key issue for
medication cabinet. Through
investigation found not enough
key was a contributing to
cabinet being unlocked
Locks were change to
combination lock

QA measures
Pharmacy with Compliance
and department manager will
monitor all medication
cabinets, Anesthesia carts
And Redi Care for proper
storage.
If meds are found out of
compliance then an Med error
occurrence report will be filled
out.
Med Error Occurrence reports
will be trended and reported to
both QA and P&T committees

A502 & A503
Completion date:
4/19/2010

A505
Education of current policy
Policy "Medication storage review
and inspection" #2336
Policy revision "Multiple single
dosage" #2340

A505
All departments will allow pharmacy
to inspect medication for expired
dates
This does include Anesthesia carts
in both L&D and OR

A505 – A747
Multiple single dosage policy was
revised to include the management
of an open vial.
Employee will label with sticker and
mark expiration date 30 days from
the opening of the vial.

QA Measure
Pharmacy will discard any MDV
found without written expiration
date
As defined per policy

CCN medication moved to new
location with lock
Cabinet.
CCN will allow pharmacy to inspect
medication for expiration

QA Measures
Medications found out of date by
staff members other than pharmacy
will be reported on a Med error
occurrence report

QA Measures
Opened MDV's with out written date
will be reported as a med error
occurrence report

A505
Completion date:
4/19/2010

DEPARTMENT: Pharmacy		CHAPTER: Pharmacy	
POLICY: MEDICATION STORAGE, INSPECTION AND REVIEW			
APPROVED DATE: 4/09/2010	REVISED DATE: 10/09/2010	POLICY #: 2336	Page 1 of 2

PURPOSE

To verify and promote appropriate storage of medications.

POLICY

All areas where medications are stored in the Facility shall be inspected by the Pharmacist or pharmacy technician. Incorrect storage will be corrected; unusable medication will be removed from use immediately.

PROCEDURE

1. All areas where medications are stored will be inspected by the Pharmacist or pharmacy technician. Emergency medications (Crash Cart) and controlled substances (narcotic cabinet) will be included in the review.

2. Drug storage will be evaluated based on the following criteria and recorded on the "Pharmacy Review Checklist" form:

    2.1 Cleanliness and lack of clutter.

    2.2 Refrigerator temperature must be maintained between 36 and 46 degrees F.

        2.2.1 Refrigerator's that have medication stored in them must have daily temperature log recording current temperature (weekend except with monitor to check history temperatures). If refrigerator is outside normal limits notify pharmacy immediately for medication inspection and/or removal.

        2.2.2 Refrigerator with medication stored in them must be plugged into a red outlet.

    2.3 Medications will be kept in refrigerators dedicated for that use only, and must **not** be kept with biological or food items

    2.4 Medications will be stored at appropriate temperature, relative to stability.

    2.5 Light sensitive medications are protected from light.

    2.6 Emergency drugs are intact and within dating.

    2.7 Any recalled medications returned to the supplier or manufacturer.

    2.8 Security of controlled drugs is maintained and records of use properly prepared and current.

    2.9 Expired medications not available for use. A monthly inspection of medications including MDV will ensure expired medications are managed and removed from patient areas.

2.10 Poisons stored separately.

2.11 External medications separated from internal medications.

2.12 Medications that have been damaged or have illegible labels are unavailable for use or have been returned to the supplier.

3. The Pharmacist will review all inspection. Any problems noted will be corrected as soon as possible.

4. Daily review of the temperature of each refrigerator will be made by the Facility staff. Adjustments to the refrigerators will be made as appropriate to keep the temperature range between 36 and 46 degrees F.

Associated Documentation

Form ? Refrigerator Temperature

Cross-Reference Documentation

Policy ? Pharmacy Review

Form ? Pharmacy Review Checklist
Form ? Pharmacy Consultant Agreement

	DEPARTMENT: Redicare		CHAPTER:	
	POLICY: Pharmaceutical Representatives and Medication Sampling			
	APPROVED DATE: 4/09/2010	REVISED DATE: 4/09/2011	POLICY #: 3522	Page 1 of 2

RediCare policy regarding pharmaceutical representatives and medication sampling-#3522

BACKGROUND

The interactions between provider and pharmaceutical representatives have received increased attention and regulation due to the effect of such interactions on provider prescribing habits and ultimately increasing consumer costs. Such concerns are balanced against the positive results of physician education and patient benefits of convenience and individual cost savings.

PURPOSE

This policy will establish the boundaries for visits between Mountain View Redicare providers and representatives. This policy also establishes the procedure for representatives to leave pharmaceutical samples and sample monitoring.

REPRESENTATIVE VISITS

1. The representative will check in at reception, who will then notify the provider. As appropriate, the provider will authorize the representatives' visit and will monitor (or delegate such monitoring) the representative's visit. Representatives will not be allowed in areas containing open patient information or the locked pharmaceutical samples area.

2. Providers and staff may accept items from representatives in accordance to current industry standards and AMA ethical guidelines. Such interactions should have a clearly definable educational purpose.

SAMPLING

1. The representative may leave pharmaceutical samples according to guidelines established by hospital policy. Samples of medication with potential for abuse, misuse, or dependence will never be accepted. The provider or delegate shall receive and stock the samples. The following list enumerates appropriate and acceptable samples for Redicare use:

    1.1. Antibiotics: topical and oral

    1.2. Antivirals: topical and oral

    1.3. ENT: Decongestants, antihistamines, nasal steroid sprays

    1.4. Migraine: triptans

1.5. Musculoskeletal: NSAIDS, muscle relaxers

SAMPLE MONITORING AND PATIENT COST AWARENESS

1. A log shall be kept which documents that the samples were checked monthly for expired product. Expired samples shall be discarded through Mountain View Hospital pharmacy protocol. A record of samples dispensed with lot number will be recorded in the patient's chart and in an electronic spreadsheet for tracking purposes. As recommended by the AMA ethical guidelines, patients will be made aware of the true average retail cost of the samples they receive, and documentation of said awareness will placed in the patient's chart.

2. The log will be reviewed by the Pharmacy department and any correction or violations will be submitted as a medication error and reported on MVH medication error.

Reviewed 11/18/2009
MVH P & T Committee

IMOUNTAIN VIEW HOSPITAL

	DEPARTMENT: **LABOR & DELIVERY**		***CHAPTER:***
	POLICY: **GENTAMICIN ADMINISTRATION**		
	Approved: ***Date:***	***Revised Date:***	***Policy #:*** **2244**	***Page 1 of 1***

PURPOSE

To provide policy and procedure for the safe administration of intravenous antibiotic infusion of Gentamicin to the neonate.

PROCEDURE

1. Obtain physician order for Gentamicin including dose based on mg/kg, route, and time interval.

2. Verify correct patient and order with the chart. Calculate dose for mg/kg. Draw up correct amount of antibiotic in a 5ml syringe.

3. Set up syringe pump. Verify patency of the IV site. Gentamicin is always given as a piggyback into the main IV line. Set the pump to infuse the Gentamicin over 30 minutes.

4. Verify newborn ID at bedside. Connect IV tubing per protocol and start the infusion pump.

5. Do not infuse Gentamicin in less than 30 min after penicillin unless newborn is profoundly septic. Slowly flush between antibiotics with 3 ml of normal saline.

6. Draw blood for electrolytes, BUN and creatinine at or within 24 hours of first dose of Gentamicin and thereafter, as ordered by physician.

7. Draw a Gentamicin peak lab value as/if ordered by physician. Draw a serum Gentamicin trough lab value before the third dose and every 3 days per hospital while on Gentamicin or as ordered at the discretion of individual physician.

8. Fax order to pharmacy for review and MAR update

9. All infants receiving even one dose of Gentamicin will have an automatic audiology referral. This is to be done at 6 months of age if the baby passed both ears on the ABR hearing screen prior to discharge. The audiology referral should be done within 10 days of discharge if the newborn referred on one or both ears.

   Note: Serum Gentamicin levels:

   - Peak: draw 30 minutes after the infusion is completed (5-12 mcg/ml).
   - Trough: draw 30 minutes prior to giving next dose (0.5 to 2.0 mcg/ml).

Reference: Neofax: A Manual of Drugs Used in Neonatal Care, 1999, pg 32-33.

	DEPARTMENT: Pharmacy		CHAPTER: Pharmacy	
	POLICY: CONTROLLED SUBSTANCES MANAGEMENT			
	APPROVED DATE: 12/17/2008	REVISED DATE: 6/17/2009	POLICY #: 2312	Page 1 of 3

PURPOSE

To ensure proper management of controlled substances.

POLICY

A continuous record of all controlled substances in Schedules II thru V is to be maintained.

The record is verified by a physical count of these controlled substances at the beginning and end of each shift by two licensed staff personnel.

Documentation records shall be maintained in a manner to be readily retrievable.

Documentation shall be maintained for at least two years from date of the receipt of inventory.

EQUIPMENT

Controlled substances are kept in a secure double locked cabinet or container which is kept locked except when in active use. During hours of operation the narcotic key to the locked cabinet shall be carried by the Director of Nursing or designees in the PACU, Inpatient, Surgery, and Perinatal areas. Only one key to the locker is available and is kept on the person of an authorized staff person. The key is passed from person to person as needed for access to the locker during hours of operation.

Access to the Pharmacy room shall be restricted to a Pharmacist, pharmacy technician working with the pharmacist, or approved nursing personnel after hours. Access to the Medication room shall be permitted through a card key.

After hours of operations, the narcotic keys for the PACU and Surgery will be returned to the locked cabinet in the post surgical area. The narcotic key for the Inpatient and Perinatal area will be passed to next shift after narcotic counts has been completed.

PROCEDURE

1. Purchasing and Receiving:

   A. Narcotic orders are prepared by the pharmacist.

      i. Order forms shall be signed and dated by the pharmacist(s) on record with the DEA.

   B. Orders for substances designated as Schedule II must be accompanied by a completed Federal Order Form #222. The third copy of the triplicate form is retained by the Facility and copies one and two are delivered to the supplier.

i. Copy 3 from Form-222 is to be maintained in a separate file. Attached to Copy 3 should be a copy of invoice or receiving document provided by the vendor when order is received. The receiving pharmacist will verify the order received and sign the Form-222.

ii. Schedule III, IV & V are ordered on line. A copy of invoice or receiving document provided by the vendor when order is received shall be maintained in the file in accounting.

iii. Invoices for non-controlled items will also be maintained in accounting.

iv. Documentation files to be filed in a locked cabinet located in the Director of Nursing Office.????

C. Narcotic orders must be received at the Facility by a pharmacist or approved nurse.

i. Schedule II Substances must be properly executed for receipt of drugs by indicating on the Copy 3 from the order Form-222 the following:

a. The number of commercial or bulk items received for each item

b. Date received into Center

c. The initials of the pharmacist receiving order.

D. The pharmacist and/or pharmacy technician must verify and sign for the receipt of inventory into the Facility.

2. Initial and Annual Inventory Count

A. A separate initial inventory of all controlled substances on hand shall be taken when the business begins commencement. This sheet shall be filed into a file folder titled "Inventory ? Initial & Annual". Inventory count must be completed on the same day at end of year. Count shall be recorded in an Inventory form as provided by the State Board of Pharmacy.

B. Every year an inventory shall be taken and recorded. Record of this inventory count shall be filed in the "Inventory" file.

3. Documentation of Administration:

A. Narcotic Use Sheet is completed for each drug that indicates the total quantity in inventory. A separate sheet is completed for each different strength and dosage form of each drug in inventory.

B. An entry is made on the Narcotic Use Sheet for each dose administered. The entry is to include the date, time, patient name, dose, physician or anesthesiologist name, and the signature of the registered nurse.

C. The quantity remaining of the drug is reduced by the amount used for the dose.

D. Any amount not used (i.e. Fentanyl), is wasted by a nurse and a witness. The witness must be another registered nurse or a physician. An entry is made and signed by the nurse and witness.

E. Counts shall be performed twice a day, at beginning and end of day and between shifts for the inpatient area.

Associated Documentation

Form - Narcotic Use Sheet

Form ? State Board of Pharmacy Annual Count Form

PLAN FOR CORRECTION FOR CONDITIONS OF PARTICIPATION 482.26(b)(1) SAFETY FOR PATIENTS AND PERSONNEL

A536
Policy for patient protection from radiation exposure
Policy "Portable radiology procedures in CCN"
#2241

A043
Board of Manager to approve policy and process

Staff education to policy in both L&D and Radiology department via mandatory read email

Radiology department purchase several infant radiation gonad protection pads

Radiology department was educated via mandatory read email on policy and proper distance for patient and infant not being x-rayed

Radiology will not take x-ray until all appropriate personal are wearing an appropriate apron

QA Measures
All department will monitor radiology for compliance with policy. If found noncompliant then an Occurrence report will be filled out and turned into QA department.

A536
Completion
Date
4/19/2010

A724
482.41
Facilities, supply equipment maintenance

Policy for Redi-Care Lab tube expiration and inspection.

QA Measures
Lab personal will perform Lab tube inspection at the end of every month

Redi Care policy for ISTAT QA protocol
Lab Manager to review and approve process for management of ISTAT device.

QA Measures
Lab will perform quarterly audit on ISTAT QA

A043
Board of Manager to approve policy and process

A724
Completion Date
4/19/2010

	DEPARTMENT: Labor and Delivery		CHAPTER:	
	POLICY: Portable Radiology Procedures in CCN			
	APPROVED DATE: 3/11/2010	REVISED DATE: 3/11/2011	POLICY #: 2241	Page 1 of 2

PURPOSE

To provide consistent and safe care to infants receiving Portable radiology services.

PROCEDURE

1. General

1.1. The NICU RN will assist the Radiology Technologists when taking x-rays, Ultrasounds, Heart Echoes, etc.

1.2. All procedures must be ordered by a physician.

1.3. The radiology technologists will do a hand scrub before entering the NICU and put on gloves and gown.

1.4. Cover the x-ray plate with a clean plastic bag.

2. Procedure

2.1. Call radiology department.

2.2. The radiology technologist will bring the portable machine to the infants bedside, preferably an open warmer.

2.3. Shield the infant's reproductive organs for x-ray if possible.

2.4. Personnel around the infant will wear protective shields.

2.5. The RN will hold the infant still and do any repositioning, as needed, *not the technician.*

2.6. The RN will reposition the infant after the procedure and clean off any gel if used.

2.7. The RN will document type of procedure; time taken and infant's response.

MOUNTAIN VIEW HOSPITAL

	DEPARTMENT: REDI –CARE(S)		*CHAPTER:* LAB
	POLICY: **LAB TUBE MONITORING FOR EXPIRATION**		
	Approved: BOM Date: 04/09/2010	*Revised Date:*	*Policy #:* 5780
			Page 1 of 1

POLICY

Monitoring and Controlling Expired Lab Tubes at Redi-Care clinics

PROCEDURE

To ensure that no expired lab tubes are being used by Redi-care personnel

1. The Redi-Care Lab Team Lead will designate a staff member to review the inventory of lab tubes at the end of the month. The designated lab personnel will mark each box that will be expiring in the upcoming month with a sticker that states the that the tubes in the box will be expiring that month and the date on which they will expire.

2. If tubes still remain on the date of expiration, the lab personnel working that day will label each individual tube with a notice indicating that the tubes are not for patient use, or alternatively will discard the tubes.

3. This process will be monitored by the Lab Department Manager who will perform quarterly checks for compliance with policy. Any deficiencies will be noted and Director of Redi-Care will be notified along with Compliance Officer.

MOUNTAIN VIEW HOSPITAL

	DEPARTMENT: **REDI-CARE(S)**		*CHAPTER:* **LAB**
	POLICY: **LAB I-STAT QUALITY CONTROL**		
	Approved: BOM *Date: 4//09/2010*	*Revised Date:*	*Policy #:* 5912	*Page 1 of 1*

POLICY:

Maintaining quality control program for ISTAT.

PROCEDURE

Running QC on ISTAT at Redi-Care Channing way clinic

1. Redi-Care personnel will receive annual training on Quality Control for all lab procedures by the Lab Department Manager.
2. Lab Manager will review all monthly QC for ISTAT at the end of every month.

Following procedure will be followed by Redi-Care personal:

1 Lab personnel at Channing Way Redicare will run daily I-STAT controls.
Personnel will note in the log the date the controls were run and the result of such control tests.

2 If QC has been ran three times and is outside normal limits then notify Lab Manager and do not use for patient use until QC is passed.

3 The Redicare Lab Team Lead will review the log sheet weekly to ensure compliance to this policy.

PLAN OF CORRECTION FOR CONDITION OF PARTICIPATION 482.42
INFECTION CONTROL

A043
ALL POLICIES THAT HAVE CHANGES AND REVISION WILL BE SUBMITTED TO THE BOARD OF MANAGERS FOR APPROVAL

A747
Policy "Hand Hygiene"#1102

Staff education and orientation to policy by:

Hand Hygiene signs posted and change weekly on MVH intra-net site

Hand Hygiene signs posted on all patient door reminding staff.

Mandatory Hand Hygiene Health Stream course for all staff members Which includes proper PPE

Badges made to hang on all employees name badges stating "Hand hygiene saves lives"

Staff education regarding Hand Hygiene in staff meetings

QA Measures
QA department will monitor hand washing on a monthly basis
Deficiencies will be address in staff meeting

Completion Date
4/19/2010

A747
Process for weighing diapers

Diaper weighing station was moved to an appropriate distance from well baby area and closer to disposal area.

Staff members of the CCN were educated via mandatory read e-mail and staff meeting

Completion Date
4/19/2010

A747
Decontamination Of cell phone and proper use.
Policy "Cleaning Cell Phone"

Cell phone policy is posted on the intra-net

QA Measure
Cell phone use will be monitored along with Hand Hygiene by the QA department.

Completion Date
4/19/2010

A747
Central Sterile
Policies and staff education

Policy "Cleaning and care of surgical instruments and equipment" #3314
All CS staff members including tech that rotate to c-section suite along with Wound Care staff were oriented to policy and the proper dilution of detergent training was provided by CS supervisor who received training from manufacture

Policy "Sterilization Controls" # 3302 & "Care/Storage/Rotation of sterile instruments' # 3312
Both Redi-care received training on policies and the use of controls such as Bio-indicators for their perspective autoclaves.
Also on the storage and rotation of sterilized instruments per policy
All CS staff members oriented to policy via mandatory read email and staff training meetings

QA Measures
Redi Care Staff will be monitored quarterly by the CS supervisor
A member of each Redi-Care will attend at least one CS staff meeting per quarter for continuum of sterile practices

Completion Date
4/19/2010

A747
Environmental Infection control

Operating room stools
Tap has been removed and if tear then stool has been discarded.
Facility Manager

Operating room
Surgical floor
Rooms 2, 4 and 5
Contractor will repair floors
On or before 4/29/10

QA Measures
Facility Manager will inspect Operating room floors for tears quarterly and will make recommendations

Crash Cart will be inspected by the Respiratory care department on a monthly basis. Any product found open will be discarded

Wound Care department
Proper management of refrigerator for medication.
Sign was posted on Medication fridge "Medication Only"

QA Measures
An Environmental safety inspection will be conducted monthly in the following departments until found compliant for three consecutive months. Then will be inspected quarterly

- Wound Care
- Operating Room
- PACU
- Central Sterile
- Redi-Care's

Completion Date
4/19/2010

	DEPARTMENT: Compliance	CHAPTER: Infection Control	
	POLICY: HAND HYGIENE		
	APPROVED DATE: 12/11/2008 / REVISED DATE: 12/11/2009	POLICY #: 1102	Page 1 of 3

The following policy and procedure is based on the CDC Hand Hygiene Guideline in Health Care Settings published in the MMWR 2002; 51 (NO. RR-16)

PURPOSE

To reduce, as low as possible, the number of viable microorganisms on the hands in order to prevent transmission of healthcare associated pathogens from one patient to another and to reduce the incidence of healthcare associated infections.

POLICY

1. All staff will be instructed in hand hygiene as outlined below.
2. All staff are to wash or sanitize their hands immediately before and after contact with the patient or his/her environment.
3. All staff are to wash their hands after any contact with blood, body fluids, secretions, excretions or other contaminated items, whether or not gloves were worn.
4. Hands must be washed immediately after removal of gloves, between patient contact and when otherwise indicated.
5. Hands must be washed or sanitized between tasks and procedures to prevent cross contamination of different body sited on the same patient.
6. Hand washing must also be done after personal use of toilet, after coughing or sneezing, before eating, and at the beginning of shift and on completion of duty.
7. Artificial nails are not to be worn by any employee working in clinical areas. All nail tips should not exceed 1/4 inch in length.

DEFINITIONS

1. Alcohol-Based Hand Rub: An alcohol-containing preparation designed for application to the hands for reducing the number of viable microorganisms on the hands. (1 in with 2 spaces)
2. Antimicrobial Soap: Soap containing an antiseptic agent.
3. Antiseptic Agent: Antimicrobial substances that are applied to the skin to reduce the number of microbial flora. Examples include alcohols, chlorhexidine, PCMX, quaternary ammonium compounds and triclosan.
4. Plain Soap: Detergents that do not contain antimicrobial agents.
5. Waterless Antiseptic Agent: An antiseptic agent that does not require water. After applying such an agent, the hands are rubbed together until the agent has dried.

HAND WASHING PROCEDURE

1. When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or body fluids, wash hands with either non-antimicrobial or microbial soap or water. Use either type of soap and water before eating and after using the restroom.
2. Wet hands and wrists thoroughly, holding them downward over the sink so that the water runs toward the fingertips. Use warm but not hot water as hot water may increase the risk of dermatitis.
3. Take a generous portion of soap from the dispenser. Rub hands together vigorously, creating as much friction as possible.
4. Continue scrubbing for 15 seconds until areas between fingers, the backs of hands and the palms and areas around the fingernails are cleaned.
5. Rinse hands thoroughly. All soap should be carefully removed to avoid excessive drying of skin.
6. Dry wrists and hands thoroughly with a disposable towel
7. Since the faucet handle is considered to be contaminated, turn off the water by using a dry paper towel to cover the faucet handle.

ALCOHOL-BASED HAND RUB

1. If hands are not visibly soiled, use an alcohol-based hand rub for decontaminating hands in all other clinical situations:
   - A. Before direct contact with a patient's intact skin (taking a pulse or blood pressure, etc.);
   - B. Before donning sterile gloves when inserting a central intravascular catheter;
   - C. Before donning gloves to insert invasive devices;
   - D. After skin or mucous membrane contact;
   - E. Moving from a contaminated-body site to a clean-body site during patient care;
   - F. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient;
   - G. After contact with mucous membranes, non-intact skin, body fluids or excretions and wound dressings if hands are not visibly soiled.
   - H. **NOTE: Alcohol-based hand rubs are NOT effective against spore-forming bacteria, such as C-Difficile** Hands must be washed with soap, water, and friction to remove spores.

2. Apply one full squirt of the hand rub from the dispenser to the palm of one hand and rub hands together, covering all surfaces of hands and fingers, **until hands are dry.**

Mountain View Hospital
Hand Hygiene nitoring Tool

Quarter/Year: _____

Location of Observation: _____ **Monitor Name:** _____

Using Pre-Assigned Random Date & Time Schedule,
Sample 30 Observations/Unit/Qtr (10 Month) -10 MD, 10 RN, 10 Other

	Name of Person Being Observed (Those Being Observed Must Be Unaware & Non-Repeating)	Position: *Nurse Physician OtherStaff*	Observed Person's Department Or MD Dept	Date & Military Time	Circle All Contact Sites: *Skin Body Fluid (mucous mem, blood) Wound Equip/Suppl/Surfaces (around patient)*	Before Contact *Soap Alcohol Nothing*	During Contact Gloves? *(Circle)*	After Contact: *Soap Alcohol Nothing*	Nails >¼" or Artific Nails?	In Full Compliance With MVH Policy?
1		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
2		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
3		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
4		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
5		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
6		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
7		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
8		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
9		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
10		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
11		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
12		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
13		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
14		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
15		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
16		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
17		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
18		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
19		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
20		N P **O**		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
21		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
22		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
23		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
24		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
25		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
26		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
27		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
28		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
29		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N
30		N P O		/ / Tm:	Skin BF W EQ	S AL N	Y N	S Al N	Y N	Y N

	DEPARTMENT: Infection Control		CHAPTER:	
	POLICY: Cell Phones - General			
	APPROVED DATE: 4/09/2010	REVISED DATE: 4/09/2011	POLICY #: 4001	Page 1 of 1

PURPOSE

Cell phone cleaning is essential to minimize the possibility of infection by cross-contamination.

POLICY

All staff will be instructed in the Cell phone cleaning procedure.

1. Cell phones are to be cleaned immediately before contact with the patient or his/her surroundings, and immediately after contact if the phone is touched or used during patient contact.

2. If cell phone is used while wearing Personal Protective Equipment (PPE) then phone should be cleaned before removal of PPE.

PROCEDURE

1. Using a standard alcohol wipe, the cell phone surfaces should be rubbed clean and allowed to dry before use.

	DEPARTMENT: CS	CHAPTER:		
	POLICY: Care/Storage/Rotation of Sterile Instruments			
	APPROVED DATE: 4/09/2010	REVISED DATE: 4/09/2011	POLICY #: 3312	Page 1 of 3

PURPOSE

To identify the proper directions for the care, storage and rotation of sterile instruments.

POLICY

All items will be rotated on a first-in first-out basis.

1. All supplies are checked and rotated weekly.
2. When restocking supplies

    2.1. If supplies are in two (2) or more rows, place newest ones on the left side.

    2.2. Always pull supplies from the right side.

    2.3. If supplies are in one (1) row, place new supplies in the back and pull from the front side.

3. Check expiration date on each package during rotation procedure and prior to use, if event-related sterility is not used in the facility.
4. Supplies or sterile instruments that are stored first in the Surgery Department will be used first.
5. Supplies are used from right to left.
6. When new supplies or instruments are stored in operating room, supplies that are already on shelves will be moved over to the right and new supplies are placed following them.
7. Authorized personnel entering the surgical suite shall follow a well delineated traffic patter. See physical layout of Sterile Processing Policy.
8. Separate the traffic patterns for clean and sterile supplies and equipment from traffic patterns for soiled equipment and waste either by space or time.

    8.1. Clean supplies are delivered to the unrestricted are of the suite. External packing containers used during shipping, are removed before materials are transported to the surgical suite.

    8.2. Instruments and other supplies are usually reprocessed within the suite; however, the traffic pattern for these items is in one direction. Traffic pattern moves from back room decontamination area, to the work room for reprocessing and into the surgery suite for storage. Work areas are clearly identified to eliminate crossover or mixing of soiled and cleaned instruments or supplies.

8.3. Sterile supplies are stored on separate shelves from clean, nonsterile supplies to prevent inadvertent use of a nonsterile item. Storage conditions are maintained to minimize dust, moisture and insect contamination.

8.4. Storage of supplies in Surgery is kept at a minimum.

8.5. Sterile items are physically separated from soiled waste materials at all times.

PROCEDURE

For items require packaging, choose suitable size pack or wrap.

1. Plastic Peel-Pak: Nonreusable. Seal strength sufficient to contain the product during sterilization, storage, handling and yet peel with minimum fiber tear and lint.

    1.1. Label edge of Peel-Pak with name of item, date sterilized, expiration date and load number.

    1.2. Protect sharp point with tip protectors; separate all components.

    1.3. Place in Peel-Pak so that grasping area peels first.

    1.4. Insert steam sterilometer in Peel-Pak.

    1.5. Seal Peel-Pak with heat sealer two (2) times.

2. Kimguard One Step: All wrapped packages should be wrapped separately; a wrapped package within a wrapped package.

    2.1. Kimlon: Two (2) thickness of material.

    2.2. Cloth: Two (2) double thickness wrappers freshly laundered.

    2.3. Choose suitable size.

    2.4. Insert steam intercalator in center of pack.

    2.5. Follow procedure in wrap section.

    2.6. Secure wrap with steam sterilizing tape.

    2.7. Label contents of package with item name, date sterilized, expiation date and load number.

3. All items, removed from sterilizers after sterilization, should remain on the sterilizer counter until completely cooled. Ay items that are wet are unsterile.

4. There should be a minimum amount of handling of sterile items.

5. Any items that are dropped or that are touched by any wet object are considered contaminated and must be reprocessed.

6. In the event of a potential sterilization failure, as indicated by a positive S3065 or bilological indicator, the following procedure will be initiated:

   6.1. Spores Procedure:

      6.1.1. Sterile Processing Technician will notify Central Sterile Department Manager at the first indication of a possible positive indicator. (S3065 takes 48 hours, but a reading at 24 hours may give a potentially positive result.)

      6.1.2. The affected sterilizer will be immediately removed from service, until repairs are completed.

      6.1.3. The load record for the questionable load will be reviewed and all itmes listed will be removed from patient care areas and returned to Central Sterile for reprocessing.

      6.1.4. It must be assumed that any items not located have been used for patient care. All attempts shall be made to identify which patients may be affected. The surgeon must be notified immediately of the potential sterilization failure by the OR Supervisor.

      6.1.5. Contact preventative maintenance service for autoclave check.

      6.1.6. When autoclave servicing is completed repeat the spore test; following determination of negative spore test reprocess and autoclave all necessary supplies.

      6.1.7. Complete incident report.

	DEPARTMENT: CS		CHAPTER:	
	POLICY: Sterilization			
	APPROVED DATE: 4/09/2010	REVISED DATE: 4/09/2011	POLICY #: 3300	Page 1 of 3

POLICY

Every sterilized item shall have a load control identification that indicates the sterilizer used, the cycle or load and the date of sterilization.

PURPOSE

To readily retrieve items in the event of a sterilization failure.

PROCEDURE

1. Performance records for all sterilizers shall be maintained for each cycle and retained in the department.

    1.1. Time-temperature recording device and temperature and pressure gauges shall be monitored by the sterilizer operator at the beginning and end of each sterilizer cycle to verify function.

    1.2. Time-temperature recording device indicating the load number shall be maintained and changed daily by the assigned technician.

2. Information recorded from a sterilization cycle shall include the following:

    2.1. Load number

    2.2. Contents of load

    2.3. Exposure time and temperature, if not provided on chart

    2.4. Name of operator

    2.5. Results of biological monitor, where applicable

3. Record Keeping:

    3.1. Duo-record card is attached to sterilizer cart or placed in tray with items to be sterilized.

    3.2. Pertinent load information is placed on the reverse side of the card.

3.3. After a steam sterilization cycle, the large circle in the word "steam" will change from white to black.

3.4. The duo-record card is then kept on file in either the steam or gas record keeping envelope or in off sight storage.

4. Labels must contain the following information:

4.1. Label must have the Julian Calendar date of sterilization

4.2. Sterilizer number

4.3. Sterilizer run number

FLASH STERILIZATION

1. Flash Sterilization will only be used in select clinical situations and in a controlled manner.
2. Items to be flash sterilized will be subjected to the same decontamination processes as described in autoclave steam sterilizing process.
3. The same process monitoring/challenge devices will be used as those used for non-flashed items.
4. Users will adhere to aseptic technique for flash-sterilized items during transport to the point of use. It is important that sterilization processing be carried out in a clean environment and that flash-sterilization devices are transferred to the point of use in a manner that prevents contamination.
5. Rigid sterilization containers deigned and intended for flash-sterilization cycles will be used.
6. Flash-sterilization containers will be used, cleaned, and maintained according to the manufacturer's written instructions.
7. In an emergency, when flash sterilization of an implant is unavoidable, a rapid-action BI with a class 5 chemical integrating indicators (or enzyme only indicator) should be run with the load. (PNDS:170,198)

7.1. The implant will be quarantined on the back table and will no be released until the rapid-action BI provides a negative result.

7.2. If the implant is used before the BI results are known and the BI is later determined to have a positive result, the surgeon and infection prevention and control personnel will be notified as soon as the results are known.

7.3. If the implant is not used, it will not be saved as sterile for future use. Resterilization of the device is required if the implant is to be used later.

8. Documentation of cycle information and monitoring results will be maintained in a log (electronic or manual) to provide tracking of the flashed item(s) to the individual patient. Documentation allows every load of sterilized items used on patients to be traced.

	DEPARTMENT: CS		CHAPTER:	
	POLICY: Sterilization Controls			
	APPROVED DATE: 4/09/2010	REVISED DATE: 4/09/2011	POLICY #: 3302	Page 1 of 3

PURPOSE

To outline the types and use of sterilization controls in the processing of sterile products.

POLICY

1. There are three types of sterilization controls used to ensure that all parameters for effective sterilization have been met.

    1.1. Manufacturers have supplied several mechanical devices to assist in identifying and preventing malfunction and operational errors. Among these are:

        1.1.1. A recording thermometer, which gives a written report of the time and temperature of the loads processed. This graph is a permanent record for quality control.

        1.1.2. An indicating thermometer, which shows the temperature of steam at the exhaust line.

    1.2. Biological cultures or indicators are the best means of confirming the sterility of a particular article or evaluating the effectiveness of a sterilizer. Biological indicators will be performed for every load sterilized and the results recorded as a permanent record.

    1.3. Chemical controls or sterilizer indicator are used to detect cool air pockets in a sterilizer. Their limitations must be recognized. These indicators do not indicate sterilization, only that a specified temperature has been attained. There are several types of indicators including:

        1.3.1. A plastic strip impregnated with dye which when placed within a load, changes colors when exposed to steam.

        1.3.2. A sterilizer indicating tape is used to show that a pack has been exposed to steam. This does not guarantee that the pack is necessarily sterile.

2. As many sterilization controls as feasible should be used to ensure proper processing.

RESPONSIBILITY

Central Service personnel are responsible for the proper use, interpretation and documentation of sterilization controls.

BIOLOGICAL INDICATOR USE

PURPOSE

1. Attest indicators are designed to be used for specific types of sterilization. Choose the proper Attest indicator for each load.

    1.1. For steam sterilization use a Bio-challenge test pack prepared by the manufacturer.

2. After the completion of the sterilization cycle, the test package is removed and the S 3065 capsule is removed.
3. The Attest capsule is placed in the proper area of the incubator and crushed. Thc S 3065 incubator is a dual temperature model that allows the steam capsule to be processed at the same time. The S 3065 capsules must be placed in the correct area of the incubator. Correct placement of the capsules in the incubator will automatically crush the capsules, allowing release of the culture medium. An S 3065 capsule not exposed to the sterilant (control) is also marked and placed in the incubator.
4. For standard S 3065 indicators, the first reading is done in 24 hours. Compare the test capsule and control capsule. The control capsule should have turned yellow, indicating the presence off bacteria. The test capsule should remain the same color (either purple or green). Any change in color indicates a potential sterilizer failure. The recall procedure will be initiated.
5. If no color change occurs, the capsules are allowed to incubate for another 24 hours. The procedure described above is again followed.
6. Control capsules will be subjected to sterilization prior to their disposal.
7. Documentation of test results will be placed in the appropriate logbook for future reference.
8. Rapid S 3065 indicators will be processed in the rapid S 3065 incubator.
9. Rapid S 3065 indicators are crushed in crusher wall.
10. Place in incubator well for one (1) hour.
11. Place vial down into reader well.
12. Read results positive/negative.
13. Record results for control vials and indicator vials in RAPID READOUT LOGBOOK.
14. Calibrate test incubator when "Calibrate" light is blinking.
15. Calibrate by rushing processed vial in crusher well. Leave vial well one (1) minute, then press vial down in reader well until positive/negative light illuminates.

STERILIZATION OF IMPLANTABLE ITEMS

1. Items for joint replacement shall be furnished sterile form the manufacturer.
2. Implantable items such as screws and plates that are not sterile shall be steam sterilized and held in quarantine until the biological indicator reads negative.

	DEPARTMENT: CS	CHAPTER:		
	POLICY: Directions for use of steam sterilizer			
	APPROVED DATE: 4/09/2010	REVISED DATE: 4/09/2011	POLICY #: 3304	Page 1 of 4

PURPOSE

To identify the proper directions for use of the steam sterilizer. To obtain desired results from sterilization process.

EQUIPMENT

1. Steam sterilizer
2. Supplies to be autoclaved
3. Steam log
4. Loadacator gun/indicator load strip
5. Steam internal indicator
6. Steam tape external indicator
7. Wrapper or peel-pouches

PROCEDURE

1. All items to be sterilized must be clean and disassembled.
2. Individual items are either placed in peel-pouches or may be double-wrapped in disposable wrappers.
3. Trays must be carefully checked for complete contents. Always follow the Picklist when assembling trays.
4. Always place indicator inside tray/pouch in an area most difficult to sterilize.
5. Secure wrapped items with a strip of steam tape. Write name of item, department it belongs to, initials and date on the tape.

   Note: Place small piece of tape on peel-pouches which will identify that the item has been processed. It also serves as identification label.

6. "Gun" tape with label from loadacator gun. Label contains information as follows: sterilizer used, load, date

sterilized, who ran the sterilizer and date of expiration.

7. Log items on steam sterilizer log sheet.

LOADING STEAM STERILIZER

1. Place items on sterilizer cart.
2. Place flat packs on edge, permitting flow through the layers.
3. Do not crowd packs; allow adequate circulation.
4. Remember that steam flows downward.
5. Maximum pack should not exceed 12x12x20 or 25 pounds.
6. Maximum pack should not exceed 25 pounds (instruments).
7. Place bottles and basins on side or slightly inverted to allow for drainage.
8. Arrange load for least possible resistance to passage of steam.
9. When running mixed load, place metal items on bottom of rack and linen items on top rack.
10. Place peel-pouches on edges.

RUNNING STEAM STERILIZER

1. Check switches and gauges for correct settings.
    1.1. Master
    1.2. Jacket pressure must be at least 22 psi.
    1.3. All other parameters are preset by the service contract provider and must not be changed. Review these values before starting load by pressing cycle button once.
2. Push in cart and "LOCK DOOR".
3. Press cycle button #1 for morning test run.
4. During sterilization cycle run, occasionally check print-out record to determine that cycle is progressing properly.
5. When cycle is complete, buzzer will sound,
6. Open door carefully, approximately six (6) inches and leave for 15 minutes.

7. After removal, make sure load is completely cool before handling.
8. Check print-out to ensure that all the correct parameters were met. Place load sticker on print-out that corresponds with the load.
9. When load is completely cooled, return to appropriate department or storage.

EMERGENCY BREAKING OF THE STEAM STERILIZER CYCLE

The steam sterilizer cycle will not be interrupted except for emergency situations (i.e. a bad steam leak, equipment malfunction)

If steam sterilizer develops a large leakage of steam or other equipment malfunction, it may be necessary to interrupt the cycle and shut off sterilizer to prevent damage to personnel and/or equipment.

PROCEDURE

1. Push RESET button.
2. If safe, raise cover over manual handle. Watch handle go backwards to the "OFF" position and stop.
3. Contact Steris and notify the department supervisor. DO NOT OPEN THE STERILIZER.
4. The contracted service provider will be called if required to service sterilizer.

CLEANING OF STEAM STERILIZER

PURPOSE

1. To remove residue from inside of sterilizer.
2. To assure proper functioning of the sterilizer.

EQUIPMENT

1. Gloves and long sleeved gown.
2. Designated sterilizer chamber cleaning solution (directions on package)

PROCEDURE

1. Daily:

1.1. Before running first load (Bowie Dick Test), the door gasket is inspected for cracks and wiped clean of any residue.

1.2. Before running first load, (Bowie Dick Test), the lint screen from trap in front of sterilizer floor is inspected and cleaned as needed.

2. Monthly:

2.1. Prior to end of shift, the Sterile Processing Technician on duty will open sterilizer door and shut down the sterilizer by turning off the switch located behind the sterilizer. This will allow the sterilizer to cool.

2.2. Wearing a long-sleeved gown and gloves, the Sterile Processing Technician will brush down the inside of the sterilizer with solution, using long handled broom. The chamber is rinsed repeatedly with long handled mop to remove residual cleaning solution.

2.3. The cloth is then placed in plastic bag and left for Environmental Devices to lander the next day.

2.4. The sterilizer carriage is wiped clean as necessary.

PREVENTATIVE MAINTENANCE FOR STEAM STERILIZER

1. All preventative maintenance is performed by an outside contracted service provider.

2. Routine and servicing is done to ensure proper functioning of the equipment and to comply with all state and federal regulations.

3. Preventative maintenance may include calibration, lubrication, alignment, replacement of worn parts, changing or cleaning of parts and filters, early detection of impending breakdown or unsafe condition.

4. Certification is performed on a semi-annual basis by a contracted service provider.

5. Trouble/problems/questions concerning steam sterilizer or its functioning:

5.1. Any of the above may be answered by calling the contracted service provider.

6. Maintenance for steam sterilizer:

6.1. All maintenance is performed by an outside contracted service provider.

6.2. Certification is performed on an annual basis by a contracted service provider.

	DEPARTMENT: CS	CHAPTER:	
	POLICY: Directions for use of System I		
	APPROVED DATE: 4/09/2010	REVISED DATE: 4/09/2011	POLICY #: 3306	Page 1 of 4

PURPOSE

To identify the proper directions for use of the System 1. To obtain desired results from the sterilization process.

EQUIPMENT

1. System 1

2. Supplies to be sterilized

3. Cycle Log

4. Designated loadacator gun, designated load stickers

5. Internal System 1 indicator

6. External System 1 indicator tape

PROCEDURE

1. All items must be cleaned and disassembled.

2. Trays must be carefully checked for contents, (see NOTE below).

3. ALWAYS place internal indicator in items at most "difficult to sterilize" location.

4. Close door and determine that the sterilizer is ready for operation.

5. Touch start.

Note: Determine that there is NO paper, wood, fabric or any other fibrous or cellulose items in load. These will cause load to abort.

LOADING SYSTEM I STERILIZER

PROCEDURE

1. Place all scopes in correct pan.
2. Make sure to put flush port on.

RUNNING SYSTEM I STERILIZER

PROCEDURE

1. Verify cycle readiness by observing LCD message.
2. Follow correct procedure for loading sterilizer. Close door.
3. Press "Start".
4. If at any time during the cycle, there is a problem with the sterilizer or load composition, the load will automatically cancel.
5. When cycle is complete, the sterilizer will give a long beep.
6. Press cancel and open door.
7. Items may be removed and returned to the user department immediately.
8. Check print-out to ensure load parameters were met. Place loadacator sticker on print-out that matches load contents.
9. Biological test is run on Monday of each week.
10. Do not crowd, allow for adequate circulation.

PREVENTATIVE MAINTENANCE FOR SYSTEM I STERILIZER

1. All preventative maintenance is performed by the sterilizer manufacturer every quarter or semi annually.
2. After the original 1500 cycles are completed, preventative maintenance will be performed by Steris.
3. Trouble/problems/questions concerning the System I Sterilizer or its function.
    - 3.1. Any of the above may be answered by calling the contracted service provider.
    - 3.2. Sterilizer print-out will indicate if the service contractor should be notified. The central service manager should be informed when this happens.

MONITORING FOR SYSTEM I STERILIZER MECHANICAL MONITORING:

PURPOSE

To provide a record of the sterilizers performance according to the manufacturers established parameters.

EQUIPMENT

1. Sterilizer
2. Load print-out
3. Monitoring Log

PROCEDURE

1. Sterilizer provides print-out.
2. All sterilization parameters are recorded on this print-out,
3. After cycle is completed and before removing load, the print-out must be read to confirm that the parameters in all cycle phases have been met. These parameters are posted by the sterilizer.
4. Monitoring log is completed for the corresponding cycle.
5. Record keeping is the same procedure for 8 sterilizers, (see steam log).
6. Cycle and load identification by loadacator stickers follows the same procedure as for steam sterilizers.
7. Load recall procedure is the same for the steam sterilizers.
8. The System I will be known as Sterilizer 7,8.

BIOLOGICAL MONITORING FOR SYSTEM I STERILIZER

1. The System I sterilizer shall be challenged weekly with a Biological Test Pack.
2. Biological testing shall be conducted after major sterilizer repairs and with each new sterilizer installation (validation).

EQUIPMENT

1. Biological Test Pack
2. Positive control spore strip
3. Biological test log sheet

PROCEDURE

1. Criteria for Biological testing:

    1.1. The System I Sterilizer will be tested with biological indicators every Monday. The tests are recorded by the Clinical Sterile at 48 and 84 hour intervals and filed with the load history.

    1.2. Biological tests are run after mechanical repairs and routine sterilizer service is performed.

2. Completion of Cycle:

    2.1. The test pack is removed and processed as follows:

        2.1.1. #1 ? BI Test

        2.1.2. #2 ? Positive Control

            2.1.2.1. Each tube is initialed and dated, and has a loadacator sticker identifying load affixed.

    2.2. The caps of each tube are loosened and set lightly on top of the tube.

    2.3. One (1) drop of Catalase Reagent is placed in tubes # 1-3, being careful not to touch the tip or drop any other object. Set the caps back on the tubes immediately.

    2.4. Tighten the caps on tubes # 3 & 4, (Catalase and S.B Broth Control).

    2.5. Place positive control strip in #2, using one of the sterile forceps. Be careful not to touch the sides or any other object with the spore strip or forceps. The forceps shall be placed back in the peel-pouch for transport to the decontamination room to insure that no other surface is contaminated from the positive spores. The cap is tightened on tube #2.

    2.6. The test pack is opened after determining that the internal indicator has changed. The biological test strip is placed in test tube # 1 using the second sterile forceps. Again make sure that the strip does not touch any other surface. The cap is tightened and the forceps are placed back in the peel-pouch for transport to the decontamination room.

    2.7. The Biological Log sheet is filled out with the technician's name, date, time and loadacator stickers are affixed. Log results at 48 and 84 hours intervals.

    2.8. If the lot number for the test pack is needed, the number on the bottom of the test pack is used instead of the lot number on the spore strip.

    2.9. For identification purposes, all positive control strips are marked with an "x" upon receipt, to eliminate confusion when working with the tests trip and positive control strip. These positive control strips are found attached to the inside lid of the test pack box and are returned there after marking.

	DEPARTMENT: CS		CHAPTER:	
	POLICY: Physical Layout of Sterile Processing			
	APPROVED DATE: 4/09/2010	REVISED DATE: 4/09/2011	POLICY #: 3308	Page 1 of 1

PURPOSE

To describe the physical layout of Central Service.

POLICY

1. Central Service will be divided into two areas, designated as "clean" and "dirty".

2. The "dirty" area will be used for the decontamination of all soiled items, including the washing and drying of contaminated items.

3. The "clean" area will be used for processing and sterilization of clean items to include the preparation and packaging of instrument and treatment trays and sets. The steam sterilizer is located in this area.

4. These two (2) areas will be physically divided and the integrity of each area will be maintained. Only clean items will be taken into the processing area and traffic will be strictly controlled. Only properly attired personnel will enter the clean processing area.

RESPONSIBILITY

Central Service personnel are responsible for maintaining each area as designated.

	DEPARTMENT: CS		CHAPTER:	
	POLICY: Cleaning and Care of Surgical Instruments and Equipment			
	APPROVED DATE: 4/09/2010	REVISED DATE: 4/09/2011	POLICY #: 3314	Page 1 of 1

PURPOSE

Effective cleaning / processing practices of instruments / equipment will be established to control / reduce the possibility of surgical wound infections in patients. These practices will be carried out in a manner that minimized health care workers and patients exposures to potentially infectious microorganisms. The manufacturer's written instructions will be used to determine how to replicate and validate cleaning and processing methods.

PROCEDURE

1. At the end of the case the scrub will separate the instruments used during the case fro those not used and bring into decontamination room, covered.
2. Decontamination of instruments will begin immediately after the completion of any invasive procedure and each will be thoroughly cleaned prior to sterilization.
3. Using appropriate personal protective equipment, the cleaning / decontamination process will be as follows:
    - 3.1. Instruments are immersed in an approved enzymatic solution per manufacturer's recommendation with instrument jaws and ports in the open position, for a one minute soak.
    - 3.2. Using appropriate cleaning utensils, e.g. Brushes, scrubbers and pipe cleaners, clean all surfaces paying attention to small hinged joints an inside lumens in a detergent solution.
4. All cannulated instruments will be placed in the ultrasonic machine prior to mechanical washing.
    - 4.1. Visually inspect instrument for cleaning, proper functioning, defects etc.
    - 4.2. Place instrumentation into a mechanical washer.
    - 4.3. Powered surgical instruments and air hoses will **NOT** be immersed in water or place in an ultrasonic cleaner or immersed in instrument milk.
    - 4.4. Such instruments are wiped free of debris with a H20 moistened sponge and then with germicide mixture.
    - 4.5. Lubrication of powered equipment will be performed according to manufacturer's instructions.
    - 4.6. Powered equipment will be inspected for damage and wear.
    - 4.7. Items will be packaged and sterilized according to manufacturer's directions
5. All endoscopic equipment (telescopes and flexible) will be cleaned and sterilized according to manufacturer's instruction.
    - 5.1. Telescopes will be wiped with a germicidal solution.
    - 5.2. Telescopes and endoscopic equipment will be inspected at all stages of handling.

	DEPARTMENT: CS		CHAPTER:	
	POLICY: Cleaning of Anesthesia Supplies			
	APPROVED DATE: 4/09/2010	REVISED DATE: 4/09/2011	POLICY #: 3316	Page 1 of 1

PURPOSE

To ensure that all reusable anesthesia ET Blade and LMA's are cleaned and disinfected after each use.

PROCEDURE

1. Wash external and internal parts of anesthesia LMA's with a brush, mild detergent and water. A round, flexible brush may be used to clean the interior of the LMA's.
2. Inspect the LMA for integrity. If the rubber is cracked, parts of the mask are missing or the rubber cuff around the edge is leaking, give broken mask to anesthesia to discard.
3. Rinse with water.
4. Remove items, rinse with clear water and allow to air dry.
5. Wrap and sterilize.

RESPONSIBILITY

Sterile Processing Technician is responsible for the proper processing of anesthesia reusable supplies.

	DEPARTMENT: CS		CHAPTER:	
	POLICY: Sterilization of Items from Isolation			
	APPROVED DATE: 4/09/2010	REVISED DATE: 4/09/2011	POLICY #: 3318	Page 1 of 1

PURPOSE

To ensure proper sterilization of patient care supplies after use in isolation.

PROCEDURE

1. Sterilized items (instrument trays, etc.) will have all disposable items and linen removed and discarded in the appropriate receptacles. The Scrub Tech assisting with the procedure will clean all items of gross soil and cover them before sending the items to Central Service.
2. The Sterile Processing Technician will wear all appropriate decontamination apparel. The items that withstand moisture will be washed in warm water and appropriate germicidal detergent, and then ran through a complete wash cycle.
3. The instrument sets will be prepared, wrapped and sterilized according to the appropriate procedure.

RESPONSIBILITY

Central Service personnel will properly process all items, in order to render them safe for patient use.

MOUNTAIN VIEW HOSPITAL

	DEPARTMENT:		CHAPTER:	
	Pharmacy		Pharmacy	
	POLICY:			
	MULTIPLE – SINGLE DOSAGES			
	Approved: BOM	*Revised Date:*	*Policy #:*	*Page 1 of 2*
	Date: 4/9/2010		2340	

DEFINITIONS:

1. **Multiple Dose Vial (MDV):** A vial containing an injectable solution intended by the manufacturer to be used more than once. These vials contain bacteriostatic preservatives which prevent growth of bacterial contaminants.
2. **Single Dose Vials (SDV):** A vial containing an injectable solution intended by the manufacturer to be used only once. These solutions are sterile and do not contain bacteriostatic additives.
3. **Reconstituted Drugs:** Vials of a drug which must be reconstituted by the addition of a diluent (such as sterile water, saline, etc.)
4. **Refrigerated Drugs:** Drugs which are temperature labeled and must be kept under refrigeration (range of 36 to 46 degrees F) to maintain labeled potency until the labeled expiration date.

POLICY:

1. Multiple Dose Vials (MDV): All **unopened** MDV's will be held to the manufacturer's expiration date on the label. **Opened**, MDV will expire 30 days after they have been opened. *(open MDV must be dated)*
2. Single Dose Vials (SDV): SDV's are good for 24 hours after opening. They should be discarded at the end of each working day.
3. Reconstituted and Refrigerated Drugs: Manufacturer's information concerning stability will be followed with respect to the drug. All such solutions will be removed from stock and discarded if not stored according to manufacturer's recommendations; if they are not properly labeled; if there is evidence of contamination; or if the manufacturer's stability recommendations with respect to time have been exceeded.

PROCEDURE:

1. Multiple Dose Vials:

    1.1. When opening a new MDV it must be dated for expiration 30 days after opening.
    1.2. When using an opened MDV
        1.2.1. Wipe the vial diaphragm with alcohol prior to each use.
        1.2.2. Check written date of when opened MDV will expire.
        1.2.3. If MDV has been opened and does not have an written expiration date then disregard vial
        1.2.4. Use of clean sterile syringe and needle each time vial is used.

2. Single Dose Vials:

    2.1. Remove cap and wipe vial diaphragm with alcohol swab.

2.2. Discard vial appropriately after withdrawal of medication.

3. Reconstituted Drugs:

3.1. Check manufacturer's directions for reconstitution of medication and reconstitute accordingly.
3.2. Label medication vial with the following if it is to be used more than one time:
3.2.1.1.1. -Date and time of reconstitution.
3.2.1.1.2. -Concentration of resultant solution
3.2.1.1.3. -Name/identification of preparer.
3.3. Wipe the vial diaphragm with alcohol swab.
3.4. If medication vial is to be used for multiple doses, store according to manufacturer's recommendations for stability (temperature, light protection, time, etc.).

4. Refrigerated Drugs:

4.1. Medications requiring refrigeration by the manufacturer are to be stored in a refrigerator maintained in the temperature range of 36 to 46 degrees F.
4.2. If permitted by the manufacturer, a supply of medication normally requiring refrigeration may be kept at room temperature if the following is completed:

4.3. Date removed from refrigeration and room temperature storage begins is written on label.
4.4. The manufacturer's recommended limits for "room temperature" are not exceeded (normally 25 to 30 degrees C).
4.5. The expiration date is revised to reflect lower stability as recommended by the manufacturer or other documented literature source.

5. The drug is removed from stock and disposed of when the revised expiration date has been reached as indicated by the date when room temperature storage began. If not dated, the drug will be assumed to have reached the expiration date and will not be used.

6. Check vials prior to each use to insure medication is not outdated by either manufacture date and or written date for MDV or visibly contaminated.

PLAN OF CORRECTION FOR CONDITIONS OF PARTICIAPTION 482.51(b)(1) HISTORY AND PHYSICAL & FORM AND RETENTION OF RECORDS 482.24

A043 BB115
ALL CHANGES IN POLICIES AND PROTOCOLS WILL BE SUBMITTED TO BOARD FOR APPROVAL

A952 BB283 BB317
PRIOR TO SURGERY OR A PROCEDURE REQUIRING ANESTHESIA SERVICES AN ASSESSMENT AND UPDATE TO THE HISTORY AND PHSYSICAL WILL BE PERFORMED

Educate medical staff with requirements of history and physical and review of current MVH policy which includes an assessment, signature time and date be on the medical record prior to surgery or procedure.
Letter sent to all medical staff with copy of COP 482.22©(5)(ii)

Meeting with Medical Director to inform him of the compliance plan and measure in noncompliant

Review H&P requirement with MVH Operating room staff including pre-op

Purchase stamp to be placed on H&P the day of just prior to surgical procedure that states
" H&P has been reviewed & update Date: and Provider:"
Stamp requires both a date and a provider signature prior to procedure or surgery.

BB115
BB124
A043
QA Measures
All procedures will not be allowed to proceed unless emergent without an updated and complete H&P. This process will be performed by pre-op nurses.
If staff member is noncompliant than Medical Director shall be contacted along with Compliance Officer.
If the H&P is noncompliant and the procedure proceeded an Occurrence Report will be filled out including providers name and circulating OR nurse's name.
This will be reviewed by QA and the medical Director who will trend reports and make provider recommendations.

Data will be reviewed by Administration, Board of Managers and Medical Executive Committee when needed

Completion date
4/19/2010

A438 BB283 BB317
A open chart review will be performed on medical records by night staff to note any documentation correction that need to be addressed for next day staff
Will trend and author education
Findings will be reviewed by QA Committee monthly

A438 BB317
Medical records department will perform chart review with CMS chart audit tool all noncompliant medical records will be trended and address by the QA committee and reviewed by the Medical director
Summary of finding will be review by Board Of Managers at board meetings

Completion date
4/19/2010

	DEPARTMENT: Compliance	CHAPTER: Medical Staff	
	POLICY: History & Physical Medical Staff		
	APPROVED DATE: 3/11/2010 / REVISED DATE: 3/11/2011	POLICY #: 3650	Page 1 of 4

PURPOSE

Define requirements for history and physicals at Mountain View Hospital.

POLICY

A medical history and physical examination shall in all cases be performed and written or dictated no more than 30 days prior to admission or within 24 hours following admission of the patient, and authenticated by a physician who is a member of the Medical Staff.

The history and physical shall include a comprehensive current physical assessment of pertinent systems of the body and must also include the impression or reason for hospitalization/procedure/surgery as well as the plan for treatment per the Documentation in the Medical Record hospital policy.

PROCEDURE

1. **Admission H&P** ? An H&P would meet the requirement that an H&P be performed no more than 30 days prior to admission or within 24 hours after admission if:

   A. The H&P was performed within 30 days prior to the hospital admission; AND

   B. An appropriate assessment,
   to include a physical examination of the patient to update any components of the patient's current medical status that may have changed since the prior H&P or to address any areas where more current data is needed, regardless of whether there were any changes in the patient's status,
   was completed within 7 days prior to admission or 24 hours after admission confirming that the necessity for the care is still present and the H&P is still current. This updated assessment should be recorded in the admission progress note or on the original H&P document.

   C. The H&P, including all updates and assessments, must be physically present within 24 hours after admission in the patient's medical record for this admission.

   D. **If the patient is being admitted for a procedure/surgery or if during hospitalization a procedure/surgery is required, an update uote must be on or attached to the H&P immediately prior to procedure/surgery.** By definition, a procedure involves the puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, and implantations. The definition excludes peripheral venipuncture and intravenous therapy. Any procedure/surgery which employs the use of moderate sedation requires an H&P to be present.

2. **Outpatient Procedure/Surgery H&P** ? An H&P would meet the requirement that there must be a complete history and physical work-up in the chart of every patient prior to procedure/surgery if:

   A. The H&P was performed within 30 days prior to the outpatient procedure/surgery; AND

   B. An appropriate assessment, to include a physical examination of the patient to update any components of the patient's current medical status that may have changed since the prior H&P or to address any areas where more current data is needed, regardless of whether there were any changes in the patient's status, was completed within 7 days prior to procedure/surgery confirming that the necessity for the procedure/surgery is still present and the H&P is still current. This updated assessment should be recorded in the admission progress note, pre-anesthesia evaluation or on the original H&P document, AND

   C. The physician or other individual qualified to perform the H&P writes an update note addressing the patient's current status, regardless of whether there were any changes in the patient's status immediately prior to procedure/surgery. The update note must be on or attached to the H&P; AND

   D. The H&P, including all updates and assessments, must be included in the patient's medical record, except in emergency situations prior to procedure/surgery.

   E. An H&P is also required for all outpatient procedures/surgeries with the following exceptions: CT scans and MRIs, diagnostic lumbar punctures, epidural steroid injections, paracentesis, thoracentesis, joint aspirations, or injections, facet injection, EEG studies, fine needle aspiration, drainage tube exchanges or injections, needle aspirations/biopsy of superficial organs (i.e. thyroid, breast), bone marrow aspiration and biopsy, nasogastric tube placement.

3. **Obstetric H&P** ? A copy of the prenatal H&P done at the initiation of prenatal care, along with notes of the course of prenatal care, may serve as the H&P for patients admitted to obstetrics. An appropriate assessment (to include an updated physical examination and information where more current data is needed) shall be recorded in the admission progress note to authenticate the prenatal H&P.

4. **Emergency Procedure/Surgery** - Except in extreme emergencies, the patient's H&P, any laboratory and x-ray results, the preoperative diagnosis and a properly executed consent form must be present on the medical record prior to performing any procedure/surgery. If the H&P is not completed prior to procedure/surgery, the patient's surgery will be cancelled,
   unless the surgeon states in writing that such a delay would constitute a hazard to the patient and documents in the progress or admission note describing a brief history and appropriate physical findings and the preoperative diagnosis is recorded in the medical record before procedure/surgery.

5. **Physician Responsibility to Update Inpatient Documentation Prior to Procedure/Surgery** - The update to the patient's condition is usually documented in the Progress Notes.
   Any changes in the patient's condition after the H&P prior to procedure/surgery should be documented in the progress notes including pertinent interval hospital event(s) i.e. AMI during hospitalization and prior to surgery.

6. All H&Ps shall be written or dictated by a qualified provider who is a member of the medical staff. Oral and maxillofacial surgeons may be allowed to perform history and physical examinations by the granting of specific privileges to do so based on training, competence and experience respective to their areas of expertise only. Dentists are responsible for the part of their patients' history and physical examinations that relate to dentistry. Podiatrists may be allowed to perform history and physical examinations for ASA class 1 & 2 patients by the granting of specific privileges to do so based on training competence and experience respective to their areas of expertise only. For non-ASA Class 1 & 2 patients Podiatrists are responsible for the part of their patients' history and physical examinations that relate to podiatry. For dental admissions, the full H&P examination must be completed by the appropriate qualified p member of the medical staff. The supervising physician may authorize medical staff assistants, to take a medical history and perform a physical examination, record pertinent data and write progress notes in the medical record that are then required to be reviewed by a physician prior to any procedu /surgery or within 24 hours, whichever occurs first.

7. When a patient is readmitted within 7 days for the same medical problem, an interval H&P reflecting any subsequent changes and the reason for readmission may be used in the medical record.

8. If a patient is transferred from another hospital, the H&P from the transferring hospital may be used only if it has been done by a physician who is a member of the Medical Staff and only if it has been done within the above stated conditions. If the H&P is to be used from the transferring hospital, a durable, legible copy of the report may be used in the patient's hospital medical record, provided that any subsequent changes have been documented on the report. If there are no changes, the physician must indicate so and sign the updated note.

9. A dictated H&P or comprehensive hand-written Short Stay H&P will be accepted as meeting the requirements of an H&P prior to procedure/
   surgery without further review of the content of the document. Any other document thought to be the physician's H&P is to be reviewed for presence of required content before assuming it meets the requirements of an H&P. Components which must be present include chief complaint, history, physical exam (which at least includes reference to heart, lungs, neuro or mental status), impression and plan.

10. Action when H&P not present: If it appears a patient will be going to have a procedure/
    surgery without an H&P which meets the above requirements, the following steps shall be taken:

    A. Upon preparation for procedure/
       surgery, the RN determines the presence of an H&P. If not present to meet all of the above, the RN notifies the surgeon.

B. Unless the physician indicates the H&P will be written in the holding area, the patient is not to be transferred to the holding area.

C. If the H&P is not on the chart within 30 minutes of the scheduled procedure/ surgery and the surgeon has not indicated the H&P will be written prior to procedure/ surgery, the nurse shall page one of the following to assist in the resolution of the H&P:

i. Chairman of Surgical Services Department

ii. Chief Nursing Officer

iii. Chief of Medical Staff/Medical Director

iv. Administrator on Call

v. Department Manager

vi. Compliance Officer

D. Surgery staff may not take the patient to the procedure/surgery until approved by one of the above persons.

REFERENCES:

- CMS Clarification dated January 28, 2002
- JCAHO Clarification dated June 16, 2006

ATTACHMENTS/ILLUSTRATIONS:

Flowchart

MOUNTAIN VIEW HOSPITAL

	DEPARTMENT: **BUSINESS OFFICE**		*CHAPTER:* **MEDICAL RECORDS**
	POLICY: **LEGAL MEDICAL RECORD STANDARDS**		
	Approved:BOM *Date: 7/9/2009*	*Revised Date:*	*Policy #:* 591	*Page 1 of 18*

PURPOSE

To establish guidelines for the contents, maintenance, and confidentiality of patient Medical Records that meet the requirements set forth in federal and State laws and regulations, and to define the portion of an individual's healthcare information, whether in paper or electronic format, that comprises the medical record. Patient medical information is contained within multiple electronic records systems in combination with financial and other types of data. This policy defines requirements for those components of information that comprise a patient's complete "*Legal Medical Record.*"

DEFINITIONS

Medical Record: The collection of information concerning a patient and his or her health care that is created and maintained in the regular course of Mountain View Hospital (MVH) business in accordance with MVH policies, made by a person who has knowledge of the acts, events, opinions or diagnoses relating to the patient, and made at or around the time indicated in the documentation.

- The medical record may include records maintained in an electronic medical / record system, e.g., an electronic system framework that integrates data from multiple sources, captures data at the point of care, and supports caregiver decision making.
- The medical record excludes health records that are not official business records of MVH, such as personal health records managed by the patient.

Each Medical Record shall contain sufficient, accurate information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers. The information may be from any source and in any format, including, but not limited to print medium, audio/visual recording, and/or electronic display.

The Medical Record may also be known as the "***Legal Medical Record***" or "***LMR***" in that it serves as the documentation of the healthcare services provided to a patient by MVH, MVH RediCare, MVH therapy clinics, MVH physicians or MVH providers and can be certified by the MVH Record Custodian(s) as such. .

The Legal Medical Record is a subset of the ***Designated Record Set*** and is the record that will be released for legal proceedings or in response to a request to release patient medical records. The Legal Medical Record can be certified as such in a court of law.

Designated Record Set ("DRS"): A group of records that include protected health information (PHI) and that is maintained, collected, used or disseminated by, or for, a covered entity (e.g. Mountain View Hospital) for each individual that receives care from a covered individual or institution. The DRS includes:

1. The medical records and billing records about individuals maintained by or for a covered health care provider (can be in a business associate's records);

2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
3. The information used, in part or in whole, to make decisions about individuals.

Protected Health Information ("PHI"): PHI is individually identifiable health information that is transmitted or maintained in any medium, including oral statements.

Authentication: The process that ensures that users are who they say they are. The aim is to prevent unauthorized people from accessing data or using another person's identity to sign documents.

Signature: A signature identifies the author or the responsible party who takes ownership of and attests to the information contained in a record entry or document.

Clinic Record / Shadow File: A folder containing COPIES ONLY of information from the medical record used primarily by clinicians in their office or clinic setting. These COPIES of the relevant documents from the original medical record are NOT part of the legal medical record.

POLICY / PROCEDURES

I. Maintenance of the Medical Record

A. A Medical Record shall be maintained for every individual who is evaluated or treated as an inpatient, outpatient, or walk-in patients of MVH hospital, MVH RediCares, or MVH therapy clinics.

B. Currently, the Medical Record is considered a hybrid record, consisting of both electronic and paper documentation. Documentation that comprises the Medical Record may physically exist in separate and multiple locations in both paper-based and electronic formats. (See Appendix A).

C. The medical record contents can be maintained in either paper (hardcopy) or electronic formats, including digital images, and can include patient identifiable source information, such as photographs, films, digital images, and fetal monitor strips and/or a written or dictated summary or interpretation of findings.

D. The current electronic components of the Medical Record consist of patient information from multiple Electronic Health Record source systems. The intent of MVH is to integrate all electronic documents into a permanent electronic repository.

E. Original Medical Record documentation must be sent to the designated Medical Records department or area. Whenever possible, the paper chart shall contain original reports. Shadow files maintained by some clinics or care sites contain copies of selected material, the originals of which are filed in the patient's permanent Medical Record.

F. Medical Record offsite Storage

II. Confidentiality

The Medical Record is confidential and is protected from unauthorized disclosure by law. The circumstances under which MVH may use and disclose confidential medical record information is set forth in the Notice of Privacy Practices (*see*: Privacy Policy "*Notice of Privacy Practices*") and in other MVH Privacy Policies and Procedures.

III. Content

A. Medical Record content shall meet all State and federal legal, regulatory and accreditation requirements including but not limited to Idaho Administrative Code IDAPA 16.03.14 – Rules & Minimum Standards for Hospitals in Idaho, and the Medicare Conditions of Participation 42 CFR Section 482.24. Appendix A contains a listing of required Medical Record documentation content, and current electronic or paper format status.

B. Additionally, all hospital records and hospital-based clinic records must comply with the applicable hospital's Medical Staff Rules and Regulations requirements for content and timely completion.

C. All documentation and entries in the Medical Record, both paper and electronic, must be identified with the patient's full name and a unique MVH Medical Record number. Each page of a double-sided or multi-page form must be marked with both the patient's full name and the unique Medical Record number, since single pages may be photocopied, faxed or imaged and separated from the whole.

D. All Medical Record entries should be made as soon as possible after the care is provided, or an event or observation is made. An entry should never be made in the Medical Record in advance of the service provided to the patient. Pre-dating or backdating an entry is prohibited.

IV. Medical Record vs. Designated Record Set

A. Under the HIPAA Privacy Rule, an individual has the right to access and/or amend his or her protected health (medical record) information that is contained in a "designated record set." The term "designated record set" is defined within the Privacy Rule to include medical and billing records, and any other records used by the provider to make decisions about an individual. In accordance with the HIPAA Privacy Rule, MVH has defined a "designated record set" to mean the group of records maintained for each individual who receives healthcare services delivered by a healthcare provider, which is comprised of the following elements:

1. The Medical Record whether in paper or electronic format, to include patient identifiable source information such as photographs, films, digital images, and fetal monitor strips when a written or dictated summary or interpretation of finding has not been prepared;

2. Billing records including claim information; and
3. All physician or other provider notes, written or dictated, in which medical decision-making is documented, and which are not otherwise included in the Legal Medical Record (e.g., outside records, email when applicable for treatment).

B. The Medical Record generally excludes records from non-MVH providers (i.e., health information that was not documented during the normal course of business at a MVH facility or by a MVH provider). However, if information from another provider or healthcare facility, or personal health record, is used in providing patient care or making medical decisions, it may be considered part of the MVH Designated Record Set, and may be subject to disclosure on specific request or under subpoena. Disclosures from medical records in response to subpoenas will be made in accordance with applicable Campus policies.

V. Who May Document Entries in the Medical Record: Multidisciplinary Notes

Only the following types of MVH employees and/or employees of MVH-contracted clinical and social services providers may document entries in the Multidisciplinary Notes section of the Medical Record:

- Clinical Social Workers
- Dentists
- Dietitians
- Hyperbaric Technicians/Observers
- Interpreters (Employees of MVH)
- Lactation Specialists
- Licensed Practical Nurses
- Nurse Practitioners
- Nurses employed by physicians (exceptions)
- Occupational Therapists
- Pharmacists
- Physical Therapists
- Physician Assistants
- Physicians including MD's and DO's
- Podiatrists
- Psychologists

- Registered Nurses
- Midwives
- Respiratory Therapists
- Speech Pathologists
- Students, e.g., MD, RN, Occupational Therapy, etc. (Notations in the record must be co-signed by a supervising clinician)
- Others as designated by Medical Center Policies and /or Medical Staff Bylaws

VI. Completion, Timeliness and Authentication of Medical Records

A. All inpatient Medical Records must be completed within 30 days from the date of discharge (Idaho Administrative Code IDAPA 16.03.24, and Medicare Conditions of Participation 42 CFR Section 482.24.). Additional requirements may also be included in the applicable MVH Medical Staff By-Laws and/or Rules and Regulations.

B. All operative and procedure reports must be completed immediately after surgery.

C. All Medical Record entries are to be dated, the time entered, and signed.

D. Certain electronic methods of authenticating the Medical Record, including methods such as passwords, access codes, or key cards may be allowed provided certain requirements are met. The methodology for authenticating the document electronically must comply with MVH electronic signature standards (*See Section XII below: Authentication of Entries*). The entries may be authenticated by a signature stamp or computer key, in lieu of a medical staff member's signature, only when that medical staff member has placed a signed statement with the Medical Center to the effect that the member is the only person who: 1) has possession of the stamp or key (or sequence of keys); and 2) will use the stamp or key (or sequence of keys).

E. Fax signatures are acceptable.

VII. Routine Requests for Medical Records for Purposes of Treatment, Payment and Healthcare Operations ("TPO")

A. The Health Information Management Services staff will process routine requests for Medical Records. All charts physically removed from the Medical Record storage areas will be logged, e.g., using a computerized tracking system or written log.

B. Only authorized MVH workforce members may access Medical Records in accordance with Privacy Policy and Procedure, "*Employee Access to Protected Health Information ("PHI").* MVH Workforce members who access Medical Records for payment or healthcare operations are

responsible to access only the amount of information in medical records which is necessary to complete job responsibilities.

1. Access to Medical Records for Treatment Purposes: Healthcare providers who are directly involved in the care of the patient may access the full Medical Record.
2. Payment Purposes: Authorized and designated MVH workforce members may access the patient's medical record for purposes of obtaining payment for services, including the following uses:
    a. Coding and abstracting;
    b. Billing including claims preparation, claims adjudication and substantiation of services;
    c. Utilization Review; and
    d. Third Party Payor Reviews (including Quality Improvement Organization reviews).
3. Healthcare Operations: Patient medical records may be accessed for routine healthcare operation purposes, including, but not limited to:
    a. Peer Review Committee activities;
    b. Quality Management reviews including outcome and safety reviews;
    c. Documentation reviews; and
    d. Teaching.
4. Requests for Electronic Components of the Medical Record: Personnel who access the electronic Medical Record are required to have a unique User ID and password, and access to information is limited according to the minimum necessary rule and managed by role, as approved by designated management personnel.

VIII. Ownership, Responsibility and Security of Medical Records

A. All Medical Records of MVH patients, regardless of whether they are created at, or received by, MVH, and patient lists and billing information, are the property of MVH. The information contained within the Medical Record must be accessible to the patient and thus made available to the patient and/or his or her legal representative upon appropriate request and authorization by the patient or his or her legal representative.

B. Responsibility for the Medical Record. The MVH Director of Medical Information (Health Information Services) is designated as the person responsible for assuring that there is a complete and accurate medical record for every patient. The medical staff and other health

care professionals are responsible for the documentation in the medical record within required and appropriate time frames to support patient care.

C. **Original records may not be removed from MVH facilities and/or offices except by court order, subpoena, or as otherwise required by law.** If an employed physician or provider separates from or is terminated by MVH for any reason, he or she may not remove any original Medical Records, patient lists, and/or billing information from MVH facilities and/or offices. For continuity of care purposes, and in accordance with applicable laws and regulations, patients may request a copy of their records be forwarded to another provider upon written request to MVH.

D. Medical records shall be maintained in a safe and secure area. Safeguards to prevent loss, destruction and tampering will be maintained as appropriate. Records will be released from Health Information Management Services only in accordance with the provisions of this policy and other MVH Privacy Policies and Procedures.

E. Special care must be exercised with Medical Records protected by the State and federal laws covering mental health records, alcohol and substance abuse records, reporting forms for suspected elder/dependent adult abuse, child abuse reporting, and HIV-antibody testing. (Refer to Policy "*Authorization for Use/Disclosure of PHI*".)

F. Chronology is essential and close attention shall be given to assure that documents are filed properly, and that information is entered in the correct encounter record for the correct patient, including appropriate scanning and indexing of imaged documents.

IX. Retention and Destruction of Medical Records

All Medical Records are retained for at least as long as required by State and federal law and regulations, and MVH policies and procedures (see: *"Records Retention"* and *"Records Storage and Destruction"*). The electronic version of the record must be maintained per the legal retention requirements as specified in "*Record Retention*".

A. In the event that an original Medical Record cannot be located, a temporary medical record folder will be created as follows:

1. All identified original documentation held for filing in the original record will be included in the temporary folder;
2. A notation will be made in the record by the Medical Records Department Supervisor or Manager that the record is a temporary chart being used until the original can be located;
3. As needed, online documents will be printed and filed into the temporary folder;

4. The temporary folder will be tracked in the computerized chart tracking system or the written log by means of a special volume number to distinguish it from the original and to indicate that it is a temporary chart;
5. Upon location of the original record, all material from both the original and temporary folder will be incorporated into the original folder.

X. Maintenance and Legibility of Record

All Medical Records, regardless of form or format, must be maintained in their entirety, and no document or entry may be deleted from the record, except in accordance with the destruction policy (refer to section IX).

Handwritten entries should be made with permanent black or blue ink, with medium point pens. This is to ensure the quality of electronic scanning, photocopying and faxing of the document. All entries in the medical record must be legible to individuals other than the author.

XI. Corrections and Amendments to Records

When an error is made in a medical record entry, the original entry must not be obliterated, and the inaccurate information should still be accessible.

The correction must indicate the reason for the correction, and the correction entry must be dated and signed by the person making the revision. Examples of reasons for incorrect entries may include "wrong patient," etc. The contents of Medical Records must not otherwise be edited, altered, or removed. Patients may request a medical record amendment and/or a medical record addendum. *(Refer to Medical Record Amendment form)*

A. Documents created in a paper format:
    1. Do not place labels over the entries for correction of information.
    2. If information in a paper record must be corrected or revised, draw a line through the incorrect entry and annotate the record with the date and the reason for the revision noted, and signature of the person making the revision.
    3. If the document was originally created in a paper format, and then scanned electronically, the electronic version must be corrected by printing the documentation, correcting as above in (2), and rescanning the document.
B. Documents that are created electronically must be corrected by one of the following mechanisms:
    1. Adding an addendum to the electronic document indicating the corrected information, the identity of the individual who created the addendum, the date created, and the electronic signature of the individual making the addendum.

2. Preliminary versions of transcribed documents may be edited by the author prior to signing. A transcription analyst may also make changes when a non-clinical error is discovered prior to signing (i.e., wrong work type, wrong date, wrong attending assigned). If the preliminary document is visible to providers other than the author, then this document needs to be part of the legal health record.
3. Once a transcribed document is final, it can only be corrected in the form of an addendum affixed to the final copy as indicated above. Examples of documentation errors that are corrected by addendum include: wrong date, location, duplicate documents, incomplete documents, or other errors. The amended version must be reviewed and signed by the provider.
4. Sometimes it may be necessary to re-create a document (e.g., wrong work type) or to move a document, for example, if it was originally posted incorrectly or indexed to the incorrect patient record.

C. When a pertinent entry was missed or not written in a timely manner, the author must meet the following requirements:

1. Identify the new entry as a "late entry"
2. Enter the current date and time – do not attempt to give the appearance that the entry was made on a previous date or an earlier time. The entry must be signed.
3. Identify or refer to the date and circumstance for which the late entry or addendum is written.
4. When making a late entry, document as soon as possible. There is no time limit for writing a late entry; however, the longer the time lapse, the less reliable the entry becomes.

D. An addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry.

1. Document the date and time on which the addendum was made.
2. Write "addendum" and state the reason for creating the addendum, referring back to the original entry.
3. When writing an addendum, complete it as soon as possible after the original note.

E. Errors in Scanning Documents

1. If a document is scanned with wrong encounter date or to the wrong patient, the following must be done:

a. Reprint the scanned document.

b. Rescan the document to the correct date or patient, and void the incorrectly scanned document in the permanent document repository.

F. Electronic Documentation – Direct Online Data Entry

Note: The following are guidelines for making corrections to direct entry of clinical documentation, and mechanisms may vary from one system to another.

1. In general, correcting an error in an electronic/computerized medical record should follow the same basic principles as corrections to the paper record.
2. The system must have the ability to track corrections or changes to any documentation once it has been entered or authenticated.
3. When correcting or making a change to a signed entry, the original entry must be viewable, the current date and time entered, and the person making the change identified.

G. Copy and Paste Guidelines

The "copy and paste" functionality available for records maintained electronically eliminates duplication of effort and saves time, but must be used carefully to ensure accurate documentation and must be kept to a minimum.

1. Copying from another clinician's entry: If a clinician copies all or part of an entry made by another clinician, the clinician making the entry is responsible for assuring the accuracy of the copied information.
2. Copying test results/data: If a clinician copies and pastes test results into an encounter note, the clinical-provider is responsible for ensuring the copied data is relevant and accurate.
3. Copying for re-use of data: A clinician may copy and past entries made in a patient's record during a previous encounter into a current record as long as care is taken to ensure that the information actually applies to the current visit, that applicable changes are made to variable data, and that any new information is recorded.

XII. Authentication of Entries

A. Electronic signatures must meet standards for:

1. Data integrity to protect data from accidental or unauthorized change (for example "locking" of the entry so that once signed no further untracked changes can be made to the entry);
2. Authentication to validate the correctness of the information and confirm the identity of the signer (for example requiring signer to authenticate with password or other mechanism);

3. Non-repudiation to prevent the signer from denying that he or she signed the document (for example, public/private key architecture).
4. At a minimum, the electronic signature must include the full name and either the credentials of the author or a unique identifier, and the date and time signed.*

B. Electronic signatures must be affixed only by that individual whose name is being affixed to the document and no other individual.

C. Countersignatures or dual signatures must meet the same requirements, and are used as required by State law and Medical Staff Rules and Regulations.

D. Initials may be used to authenticate entries on flow sheets or medication records, and the document must include a key to identify the individuals whose initials appear on the document.

E. Rubber stamp signatures: *Refer to Section VI (D).*

F. Documents with multiple sections or completed by multiple individuals should include a signature area on the document for all applicable staff to sign and date. Staffs who have completed sections of a form should either indicate the sections they completed at the signature line or initial the sections they completed.

G. No individual shall share electronic signature keys with any other individual.

XIII. Designation of Secondary Patient Information

The following three categories of data contain secondary patient information and must be afforded the same level of confidentiality as the LMR, but are not considered part of the legal medical record.

A. Patient-identifiable source data are data from which interpretations, summaries, notes, etc. are derived. They often are maintained at the department level in a separate location or database, and are retrievable only upon request. Examples:

1. Photographs for identification purposes
2. Audio recordings of dictation notes or patient phone calls.
3. Video recordings of an office visit, if taken for other than patient care purposes

   * *Acknowledge that there may be older systems that do not have this capability. Future plans for all system to meet this minimum requirement.*
4. Video recordings/pictures of a procedure, if taken for other than patient care purposes
5. Video recordings of a telemedicine consultation
6. Communication tools (i.e., Kardex, patient lists, work lists, administrative in-baskets messaging, sign out reports, FYI, drafts of notes, or summary reports prepared by clinicians, etc.)

7. Protocols/clinical pathways, best practice alerts, and other knowledge sources.
8. A Patient's personal health record provided by the patient to his or her care provider.
9. Alerts, reminders, pop-ups and similar tools used as aides in the clinical decision making process. The tools themselves are not considered part of the legal medical record. However, the associated documentation of subsequent actions taken by the provider, including the condition acted upon and the associated notes detailing the exam, are considered as component of the legal medical record. Similarly, any annotations, notes and results created by the provider as a result of the alert, reminder or pop-up are also considered part of the legal medical record.

Some source data are not maintained once the data has been converted to text. Certain communication tools are part of workflow and are not maintained after patient's discharge.

B. Administrative Data is patient-identifiable data used for administrative, regulatory, healthcare operations and payment purposes. Examples include but are not limited to:
   1. Authorization forms for release of information
   2. Correspondence concerning requests for records.
   3. Birth and death certificates.
   4. Event history/audit trails.
   5. Patient-identifiable abstracts in coding system.
   6. Patient identifiable data reviewed for quality assurance or utilization management.
   7. Administrative reports.

C. Derived Data consists of information aggregated or summarized from patient records so that there are no means to identify patients. Examples:
   1. Accreditation reports
   2. Best practice guidelines created from aggregate patient data.
   3. Public health records and statistical reports.

D. Draft Documents / Work in Progress.

   Electronic processes and workflow management require methods to manage work in progress. These work-in-progress documents often are available in the system as "draft documents, viewable to a limited number of users. They generally are not viewable to clinicians until the document is sent for final signature. Draft documents are not considered an official medical record document until it has been signed by an authorized signer.

IX. ENFORCEMENT, CORRECTIVE & DISCIPLINARY ACTIONS

Compliance with the above policy is monitored by MVH's compliance department. Violations of any of the above policy will be reported to the appropriate supervising authority and compliance/privacy officer for potential disciplinary action, up to and including termination and/or restriction of privileges in accordance with MVH Medical Staff Bylaws, and Human Resource / Personnel Policies.

X. RELATED POLICIES

- Authorization for Release of Information; and Access to the medical record
- Patient Requests for Record Amendment and Record Addendums
- Auditing of access to medical records
- "Notice of Privacy Practices"; and in other MVH Privacy Policies and Procedures.
- "Authorization for Use/Disclosure of PHI"
- Employee Access to Protected Health Information ("PHI")
- "Records Retention"
- "Records Storage and Destruction
- Verbal / Telephone Orders

XI. APPROVAL REVISION HISTORY REFERENCES

Health Insurance Portability and Accountability Act (HIPAA) Privacy & Security Rule, 45 CFR 160-164

Business Records Exception, Federal Evidence 803(6)

Idaho Administrative Code, IDAPA 16.03.14 – Rules & Minimum Standards for Hospitals in Idaho

Medicare Conditions of Participation, 42 CFR Sections 482.24.

Appendix A

Documentation Contents of the Medical Record

The medical record shall include, at a minimum, the following items (if applicable):

A. Identification information, which include but are not limited to the following:
   1. Name
   2. Address on admission
   3. Identification number (if applicable)
      a. Medicare
      b. Hospital Number
      c. Social Security Number
   4. Age
   5. Sex
   6. Marital status
   7. Legal status
   8. Mother's Maiden name
      a. Patient's Mother's maiden name
      b. Place of Birth
   9. Legal Authorization for admission (if applicable)
   10. School Grade, if applicable
   11. Religious Preference
   12. Date and time of admission (or arrival for outpatients)
   13. Date of time discharge (departure for outpatients).
   14. Name, address and telephone number of person or agency responsible for patient
   15. Name of patient's admitting/attending physician
   16. Initial diagnostic impression
   17. Discharge or final diagnosis and disposition
   18. Allergy records
   19. Advance Directives (if applicable)

20. Medical History including, as appropriate: immunization record, screening tests, allergy record, nutritional evaluation, psychiatric, surgical and past medical history, social and family history, and for pediatric patients a neonatal history
21. Physical examination
22. Consultation reports
23. Orders including those for medication, treatment, prescriptions, diet orders, lab, radiology and other ancillary services
24. Progress notes including current or working diagnosis (excluding psychotherapy notes)
25. Nurses' notes, which shall include, but not be limited to, the following:
    a. Nursing assessment including nutritional, psychosocial and functional assessments
    b. Concise and accurate record of nursing care administered
    c. Record of pertinent observations including psychosocial and physical manifestations and relevant nursing interpretation of such observations
    d. Name, dosage and time of administration of medications and treatment. Route of administration and site of injection shall be recorded if other than by oral administration
    e. Record of type of restraint and time of application and removal
    f. Record of seclusion and time of application and removal. (NPH)
26. Graphic and vital sign sheet
27. Results of all laboratory tests performed
28. Results of all X-ray examinations performed
29. Consent forms for care, treatment and research, when applicable
30. Problem List (outpatient records only)
31. Emergency Department record
32. Anesthesia record including preoperative diagnosis, if anesthesia has been administered
33. Operative and procedures report including preoperative and postoperative diagnosis, description of findings, technique used, and tissue removed or altered, if surgery was performed
34. Pathology report, if tissue or body fluid was removed
35. Written record of preoperative and postoperative instructions
36. Labor record, if applicable
37. Delivery record, if applicable
38. Physical, Occupational and/or respiratory therapy assessments and treatment records, when applicable

39. Patient/Family Education Plan (NPH Only)
40. Clinical Data set from other providers
41. Master Data Sets (as applicable to record type) including but not limited to: MDS (Skilled Nursing), OASIS (Home Health), IRF and PAI (Rehabilitation)
42. Patient Photographs when used for identification or treatment.
43. Master Treatment Plan and Reassessment (NPH only).
44. Discharge Instructions
45. A discharge summary which shall briefly recapitulate the significant findings and events of the patient's hospitalization, final diagnoses, his/her condition on discharge and the recommendations and arrangements for future care. If applicable it shall include diet and self-care instructions
46. Copies of letters to patients
47. Email communications between the patients and the provider regarding the care and treatment of the patient
48. Telephone Encounters. Documentation is required for telephone encounters with patients and/or their caregivers, or other care providers that:
    a. Provide new or renewal of prescription for medications
    b. Alter the current plan of care, including treatments and medications
    c. Identify a new system or problem and provide a plan of care
    d. Provide home care advice for symptom/problem management
    e. Provide authorization for care
    f. Provides or reinforces patient education

    Documentation should include the date and time of call, name of caller and relationship to patient (if different from patient), date and time of the response (or attempts to return call), the response given, and the signature and professional title of provider or clinic staff handling the call.
49. Primary Language

Appendix B

Medical Records Forms Standards

Appendix C

Abbreviations & Symbols

Table of Contents

Appendix A	Documentation Contents of the Medical Record		
Appendix B	Medical Records Forms Standards		
Appendix C	Medical Record: Acceptable Abbreviations & Symbols		
Appendix D	Related Policies *<optional place to list the related policies & forms>*		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130065	A. BUILDING _____ B. WING _____	03/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HOSPITAL	2325 CORONADO STREET IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 000	16.03.14 Initial Comments The following deficiencies were cited during the licensure survey of your hospital. The surveyors conducting the survey were: Patrick Hendrickson, RN, Team Leader Aimee Hastriter, RN, HFS	B 000		B000 completion date; 4/19/2010
BB115	16.03.14.200.01 Governing Body and Administration 200. GOVERNING BODY AND ADMINISTRATION. There shall be an organized governing body, or equivalent, that has ultimate authority and responsibility for the operation of the hospital. (10-14-88) 01. Bylaws. The governing body shall adopt bylaws in accordance with Idaho Code, community responsibility, and identify the purposes of the hospital and which specify at least the following: (10-14-88) a. Membership of Governing Body, which consist of: (12-31-91) i. Basis of selecting members, term of office, and duties; and. (10-14-88) ii. Designation of officers, terms of office, and duties. (10-14-88) b. Meetings, (12-31-91) i. Specify frequency of meetings. (10-14-88) ii. Meet at regular intervals, and there is an attendance requirement. (10-14-88)	BB115	REFER TO TAB 3, 5,6,7,8.	

CEO

Bureau of Facility Standards

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Facility Standards

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BB115	Continued From page 1 iii. Minutes of all governing body meetings shall be maintained. (10-14-88) c. Committees, (12-31-91) i. The governing body officers shall appoint committees as appropriate for the size and scope of activities in the hospitals. (10-14-88) ii. Minutes of all committee meetings shall be maintained, and reflect all pertinent business. (10-14-88) d. Medical Staff Appointments and Reappointments; (12-31-91) i. A formal written procedure shall be established for appointment to the medical staff. (10-14-88) ii. Medical staff appointments shall include an application for privileges, signature of applicant to abide by hospital bylaws, rules, and regulations, and delineation of privileges as recommended by the medical staff. The same procedure shall apply to nonphysician practitioners who are granted clinical privileges. (10-14-88) iii. The procedure for appointment and reappointment to the medical staff shall involve the administrator, medical staff, and the governing body. Reappointments shall be made at least biannually. (10-14-88) iv. The governing body bylaws shall approve medical staff authority to evaluate the professional competence of applicants, appointments and reappointments, curtailment of privileges, and delineation of privileges. (10-14-88)	BB115		

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BB115	Continued From page 2 v. Applicants for appointment, reappointment or applicants denied to the medical staff privileges shall be notified in writing. (10-14-88) vi. There shall be a formal appeal and hearing mechanism adopted by the governing body for medical staff applicants who are denied privileges, or whose privileges are reduced. (10-14-88) e. The bylaws shall provide a mechanism for adoption, and approval of the organization bylaws, rules and regulations of the medical staff. (10-14-88) f. The bylaws shall specify an appropriate and regular means of communication with the medical staff. (10-14-88) g. The bylaws shall specify departments to be established through the medical staff, if appropriate. (10-14-88) h. The bylaws shall specify that every patient be under the care of a physician licensed by the Idaho State Board of Medicine. (10-14-88) i. The bylaws shall specify that a physician be on duty or on call at all times. (10-14-88) j. The bylaws shall specify to whom responsibility for operations, maintenance, and hospital practices can be delegated and how accountability is established. (10-14-88) k. The governing body shall appoint a chief executive officer or administrator, and shall designate in writing who will be responsible for	BB115		

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BB115	Continued From page 3 the operation of the hospital in the absence of the administrator. (10-14-88) l. Bylaws shall be dated and signed by the current governing body. (10-14-88) m. Patients being treated by nonphysician practitioners shall be under the general care of a physician. (10-14-88) This Rule is not met as evidenced by: Refer to A043 as it relates to the Governing Body's failure to provide sufficient oversight and management necessary to ensure care was delivered in safe and sanitary manner.	BB115		
BB124	16.03.14.200.10 Quality Assurance 10. Quality Assurance. Through administration and medical staff, the governing body shall ensure that there is an effective, hospital-wide quality assurance program to evaluate the provision of care. The hospital must take and document appropriate remedial action to address deficiencies found through the program. The hospital must document the outcome of the remedial action. (10-14-88) This Rule is not met as evidenced by: Refer to A267 as it relates to the hospital's failure to ensure the Quality Assurance program fully identify internal systematic problems.	BB124		
BB175	16.03.14.310.03 Patient Care Plans 03. Patient Care Plans. Individual patient care plans shall be developed, implemented and kept current for each inpatient. Each patient care plan	BB175		

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BB175	Continued From page 4 shall include but is not limited to: (10-14-88) a. Nursing care treatments required by the patient; and (10-14-88) b. Medical treatment ordered for the patient; and (10-14-88) c. A plan devised to include both short-term and long-term goals; and (10-14-88) d. Patient and family teaching plan both for hospital stay and discharge; and (10-14-88) e. A description of socio-psychological needs of the patient and a plan to meet those needs. (10-14-88) This Rule is not met as evidenced by: Refer to A166 as it relates to the hospital's failure to incorporate restraint usage into patient care plans.	BB175		
BB221	16.03.14.330.01 Organization and Supervision 330. PHARMACY SERVICE. The hospital shall provide an organized pharmaceutical service that is administered in accordance with accepted professional principles and appropriate federal, state, and local laws. (10-14-88) 01. Organization and Supervision. Pharmacy services shall be under the overall direction of a pharmacist who is licensed in Idaho and is responsible for developing, coordinating, and supervising all pharmaceutical services in the hospital. (10-14-88) a. The director of the pharmaceutical service,	BB221		

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BB221	Continued From page 5 whether a full, part-time or a consultant member of the staff, shall be responsible to the chief executive officer or his designee. (10-14-88) b. The pharmacist shall be responsible for the supervision of the hospital drug storage area in which drugs are stored and from which drugs are distributed. (10-14-88) c. If trained pharmacy assistants, pharmacy students, or pharmacy interns are employed, they shall work under the direct supervision of a pharmacist. (10-14-88) d. If the director of the pharmaceutical service is part-time, sufficient time shall be provided by the pharmacist to fulfill the responsibilities of the director of pharmaceutical services. (10-14-88) e. The director of the pharmaceutical service shall be responsible for maintaining records of the transactions of the pharmacy as required by law and as necessary to maintain adequate control and accountability of all drugs. This includes a system of control and records for the requisitioning and dispensing of drugs and supplies to nursing units and to other department/services of the hospital, as well as records of all prescription drugs dispensed to the patient. (10-14-88) f. The pharmacist shall periodically check drugs and drug records in all locations in the hospital where drugs are stored, including but not limited to nursing stations, emergency rooms, outpatient departments, operating suites. (10-14-88) This Rule is not met as evidenced by: Refer to A490, A491, A500, A502, A503 and A505 as they relate to the facility's failure to	BB221		

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BB221	Continued From page 6 ensure adequate supervision of dispensing and storage of medications throughout the facility.	BB221		
BB283	16.03.14.360.12 Record Content 12. Record Content. The medical records shall contain sufficient information to justify the diagnosis, warrant the treatment and end results. The medical record shall also be legible, shall be written with ink or typed, and shall contain the following information: (10-14-88) a. Admission date; and (10-14-88) b. Identification data and consent forms; and (10-14-88) c. History, including chief complaint, present illness, inventory of systems, past history, family history, social history and record of results of physical examination and provisional diagnosis that was completed no more than seven (7) days before or within forty-eight (48) hours after admission; and (5-3-03) d. Diagnostic, therapeutic and standing orders; and (10-14-88) e. Records of observations, which shall include the following: (10-14-88) i. Consultation written and signed by consultant which includes his findings; and (10-14-88) ii. Progress notes written by the attending physician; and (10-14-88) iii. Progress notes written by the nursing personnel; and (10-14-88)	BB283		

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BB283	Continued From page 7 iv. Progress notes written by allied health personnel. (10-14-88) f. Reports of special examinations including but not limited to: (10-14-88) i. Clinical and pathological laboratory findings; and (10-14-88) ii. X-ray interpretations; and (10-14-88) iii. E.K.G. interpretations. (10-14-88) g. Conclusions which include the following: (10-14-88) i. Final diagnosis; and (10-14-88) ii. Condition on discharge; and (10-14-88) iii. Clinical resume and discharge summary; and (10-14-88) iv. Autopsy findings when applicable. (10-14-88) h. Informed consent forms. (10-14-88) i. Anatomical donation request record (for those patients who are at or near the time of death) containing: (3-1-90) i. Name and affiliation of requestor; and (3-1-90) ii. Name and relationship of requestee; and (3-1-90) iii. Response to request; and (3-1-90) iv. Reason why donation not requested, when applicable. (3-1-90)	BB283		

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BB283	Continued From page 8 This Rule is not met as evidenced by: Refer to A438 as it relates to the failure of the hospital to ensure medial records contained complete documentation.	BB283		
BB317	16.03.14.380.04 Records 04. Records. Prior to surgery patient records shall contain the following: (10-14-88) a. A properly executed informed consent; and (10-14-88) b. Medical history and record of physical examination performed and recorded no more than seven (7) days before or within forty-eight (48) hours after admission; and (5-3-03) c. Appropriate screening tests, based on patient needs, completed and recorded prior to surgery. (10-14-88) d. Record requirements may be modified in emergency surgery cases to the extent necessary under the circumstances. (10-14-88) This Rule is not met as evidenced by: Refer to A131 as it relates to the failure of the hospital to ensure patients were allowed to make informed decisions regarding their care.	BB317		
BB541	16.03.14.540.04 Infection Control Committee Responsibilities 04. Infection Control Committee Responsibilities. The infection control committee shall be responsible for at least the following: (10-14-88)	BB541		

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BB541	Continued From page 9 a. Designate one (1) person to act as the surveillance officer; and (10-14-88) b. Evaluating antibiotic susceptibility/resistance trends; and (10-14-88) c. Review of all infection control procedures for all departments, including housekeeping and laundry procedures, at least annually; and (10-14-88) d. Development of procedures for defining and controlling hazardous and infectious wastes; and (10-14-88) e. Continuing education for all appropriate personnel. (10-14-88) This Rule is not met as evidenced by: Refer to A747 as it relates to the failure of the hospital to ensure it provided a sanitary environment and promoted safe practices necessary to avoid sources and transmission of potential infection.	BB541		